

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13386

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14650

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 y, 6 mo, 3 d.		d. STREET ADDRESS 819 N. Castle St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Allen		4. DATE OF DEATH Month 12 Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/83
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522X Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of hip INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/25/57 to 12/28/61, that (I) (we) last saw the deceased alive on 12/28/61, and that death occurred at 4:50am M., from the causes and on the date stated above.			
22a. SIGNATURE Hilda Reissmann		22b. DATE SIGNED 12/28/61	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmann		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-9-62	
23c. NAME OF CEMETERY OR CREMATORY 21.07 Md.		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Anna. Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
DATE JAN 11 '62			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15282

(M)

DATE OF DEATH

1911

PLACE OF DEATH

NEW YORK CITY

AGE

10

SEX

MALE

RACE

WHITE

NEW YORK

CAUSE

SCURVY

PLACE OF BIRTH

NEW YORK

DATE OF BIRTH

1901

PLACE OF BIRTH

NEW YORK

DATE OF BIRTH

1901

PLACE OF BIRTH

NEW YORK

DATE OF BIRTH

1901

PLACE OF BIRTH

NEW YORK

DATE OF BIRTH

1901

PLACE OF BIRTH

NEW YORK

DATE OF BIRTH

1901

PLACE OF BIRTH

NEW YORK

115

100

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13387
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13367
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Gambrills d. STREET ADDRESS Arundel View e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard First AMES Last		4. DATE OF DEATH Month December Day 22 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76	11. IF UNDER 24 HRS. Days 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Nisners Bros. Store	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES H. AMES		14. MOTHER'S MAIDEN NAME ESTELLE DUNLON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 578 12 3498	
17. INFORMANT Mrs. Louise O. Ames		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (DO NOT SIGN) attended the deceased from Dec. 11, 1961 to Dec. 22, 1961 , that (I) (DO NOT SIGN) saw the deceased alive on Dec. 22, 1961 , and that death occurred at 8:55 AM from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck 22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22b. DATE SIGNED 12/22/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 27th Dec. 1961	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. ADDRESS Glen Burnie, Md.	23d. LOCATION (City, town or county) Fort Meyer, Va. (State)
24. FUNERAL DIRECTOR'S SIGNATURE R. T. Gough		25a. REC'D BY REGISTRAR DEC 28 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hume

13887

James H. H. H.

11 days

and several other

James H. H.

also

Engineer (1st)

James H. H.

Yes

248 12 2483

Company

James H. H.

11 days

James H. H.

James H. H.

James H. H.

James H. H.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md. X</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>				d. STREET ADDRESS <i>Rt Bot 305</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>		First <i>Anderson</i>		Middle		Last		4. DATE OF DEATH Month <i>12</i> - Day <i>10</i> - Year <i>1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>7-17-1885</i>		9. AGE (In years and months) <i>76</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Josias Brown</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Parker</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret Hall R. Bot 305 Anna</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Emphysema</i> DUE TO (c) <i>Congestive Heart Failure</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>August 4, 1961</i> to <i>December 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 10, 1961</i> , and that death occurred at <i>3 pM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Theodore H. Johnson M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Theodore H. Johnson, M.D.</i>				22d. ADDRESS <i>37 Calvert St., Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-15-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Tabor</i>		23d. LOCATION (City, town, or county) (State) <i>Chesterfield Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese # Anna Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>DEC 13 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

12063

CERTIFICATE OF DEATH

12063

[Faint, illegible text and markings on the certificate form, including fields for name, date, and cause of death.]

13369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13369

**FOR STATE
HEALTH DEPT.**

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
Anne Arundel		Maryland		Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Fort Meade				Odenton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Fort Meade Hospital		Box #335, 4th Avenue			
3. NAME OF DECEASED (Type or print)		First		Middle	
KAREN		LYNN		ASBURY	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		White		B. DATE OF BIRTH	
				9 Oct. 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Laurel Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Walter W. Asbury		Norman Lee Dragoo		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No				Walter W. Asbury- 4th Ave. Odenton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. 4933X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/28/61	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
Charles S. Petty, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12-30-61		CHEN HAVEN	
22d. LOCATION (City, town, or country)		(State)			
CHEN BURNIE, Md.					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR	
H. P. NEW & SONS		1101 N. 1st St. Baltimore, Md.		DATE JAN 3 '62	
24b. REGISTRAR'S SIGNATURE					
Arthur L. Evans					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 1 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13390

13370

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 118 Prince George St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Harvey E. Avery				4. DATE OF DEATH Month Day Year December 1 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 15 - 1897		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harbor master for Annapolis City				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Shady Side Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter S. Avery				14. MOTHER'S MAIDEN NAME Mary Ann Crandall				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>Diabetes m</u>								INTERVAL BETWEEN ONSET AND DEATH 20A 5 yr. 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1953 19 to 12-1-61, that (I) (we) last saw the deceased alive on 12-15-1961, and that death occurred on 12-1-61 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Frank M. Shipley 22c. PHYSICIAN'S NAME (Type) Frank M. Shipley M.D.				22b. DATE SIGNED 12-3-61 22d. ADDRESS Cathedral Street, Annapolis, Md.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 5th 1961		23c. NAME OF CEMETERY OR CREMATORY Woodfield Cent		23d. LOCATION (City, town or county) Galesville AAG Md			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sino				25a. REC'D BY REGISTRAR DATE DEC 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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13380

CERTIFICATE OF DEATH

13380

NAME AND ADDRESS
HOSPITAL
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION
PLACE OF REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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13391

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Items 3, 13 & 14 Film G305 1/5/62 lwk 13371

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2 Mo, 21 d.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Virginia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Rt. #3, Box 27			
3. NAME OF DECEASED (Type or print) Gurnie Ball First Alias Middle Geraldine Last Baker Baker, Geraldine alias Ball, Gurnie		4. DATE OF DEATH Month 12 Day 27 Year 1961					
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1943		9. AGE (In years last birthday) yrs. 18	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ball				14. MOTHER'S MAIDEN NAME Lottie BALL Lane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-18-7778		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor /Oligodendroglioma/ 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/6 1961 to 12/27 1961 , that (I) (we) lost saw the deceased alive on 12/27 1961 , and that death occurred at 4:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Hilda Reissmenn</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12/27/61				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmenn				22d. ADDRESS Crownsville State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Mulberry Sept. Church		23d. LOCATION (City, town, or county) (State) Emmertown Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Eugene W. Lee</i> ADDRESS 859 Maryland Warsaw Va.				25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>	



1933

REPUBLIC OF CHINA

1933

CHINESE

CHINESE

CHINESE

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13392

CERTIFICATE OF DEATH

Item 9, See City Birth Certificate # D-3372013372

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 24 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 1523 E. Chase St.											
3. NAME OF DECEASED (Type or print) First Middle Last Margery (Marjorie) (none) Bass				4. DATE OF DEATH Month Day Year 12 2 19 61											
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1928		9. AGE (In years last birthday) 33 30		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Matson T. Bass				14. MOTHER'S MAIDEN NAME Inez Bass				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Matson T. Bass 1523 E. Chase St., Balto., Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure DUE TO (b) old pulmonary tuberculosis DUE TO (c) Mongolism - Mental deficiency - Epilepsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) " " " INTERVAL BETWEEN ONSET AND DEATH Sudden															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) was found dead in bed.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1. 7. 1959. to 12. 2. 1961, that (I) (we) last saw the deceased alive on 12. 2. 1961, and that death occurred at 5:05 P.M. from the causes and on the date stated above.															
22a. SIGNATURE L. BENEDICT M.D.				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.				22d. ADDRESS CROWN SVILLE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/6/61		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION (City, town or county) (State) Arbutus Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Malcolm E. Dickman				25a. REC'D BY REGISTRAR DEC 8 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

12302

(M)

Anne Arnold County

Waltham

Waltham City

Greenville

St. Johns

Waltham City

Greenville State Hospital

1922 A. Jones St.

Barney (Meyers) (name)

name

12

3

61

Female

1922 1922

name

Waltham

U.S.A.

Station T. Jones

name

1922 A. Jones St.

no

Greenville State Hospital

1922 1922

Barney (Meyers) (name)

name

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13393

CERTIFICATE OF DEATH

13373

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box-342	
3. NAME OF DECEASED (Type or print) Lottie Elizabeth		4. DATE OF DEATH Month December Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY S. Kanns Department Store	9. AGE (In years last birthday) 82 yrs.
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Christopher Murphy		14. MOTHER'S MAIDEN NAME Catherine Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. W. Beard		Address Box 342 Shady Side Dr. Edgewater, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 519.2 DUE TO Constrictive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Massive myocardial infarction over middle lobe (c), stating the underlying cause last. Caused unknown		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 treated for similar condition June 1961		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Michael attended the deceased from Dec. 1, 1961 to Dec. 3, 1961 , that (I) Michael last saw the deceased alive on Dec. 3, 1961 , and that death occurred at 9:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/7/61	23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEMETERY PRINCE GEORGE'S, MARYLAND	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey ADDRESS 8434 GEORGIA AVENUE SILVER SPRING, MARYLAND		25a. REC'D BY REGISTRAR DEC 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Krawns			

100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13394

13374

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 15 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Odenton		d. STREET ADDRESS Box-184 A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle BEHRINGER Last BEHRINGER				4. DATE OF DEATH Month December Day 21 Year 19 61.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72	IF UNDER 24 HRS. Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Brown				14. MOTHER'S MAIDEN NAME Elizabeth Quinley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Harold Behringer Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma 260X DUE TO (b) Diabetic M. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) pneumonia?						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hr 15 y.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 12-21-	(County) Dec. 21, 1961		(State) that (I) (see) last	
21. I certify that (I) (doctor) attended the deceased from Dec. 21, 1961 , to Dec. 21, 1961 , that (I) (see) last saw the deceased alive on Dec. 21, 1961 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley		M.D. Frank M. Shipley, M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/21/61	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 26th Dec. '1961	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	23d. LOCATION (City, town or county) (State) Fort Meyer, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1988

James H. Hines

James H. Hines

James H. Hines

James H. Hines

James H. Hines

James H. Hines

James H. Hines

James H. Hines

61

Dec. 21, 1981

Frank A. Hines, Jr.

Dec. 21, 1981

Frank A. Hines, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 2 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 2 hours after death. Page 4 must be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13395

Item 9 Film G303

12/27/61 mh

CERTIFICATE OF DEATH

13375

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Gambrills	
3. NAME OF DECEASED (Type or print) First Jame Middle Betheau Last Betheau		d. STREET ADDRESS Box-340	
4. DATE OF DEATH Month December Day 17 Year 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1901
9. AGE (In years last birthday) 60 years		10. IF UNDER 1 YEAR Months 6 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Shilbert		14. MOTHER'S MAIDEN NAME Lilly Lane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give number or dates of service) 577-24-7466	
17. INFORMANT Maggie Brown - Wash. D.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Hemiplegia & aphasia DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute cardiac failure DUE TO (c) Chronic Hypertension & renal involvement		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 days 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
21. I certify that (I) (this hospital) attended the deceased from 11-20 to 12-16 , 19 61 , that (I) (we) last saw the deceased alive on 12-16 , 19 61 , and that death occurred at 11:15 AM, from the causes and on the date stated above.		22. SIGNATURE Bethau & C R Goss M.D.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-61	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Annap. Md.		25a. REC'D BY REGISTRAR DEC 21 '61	
25b. REGISTRAR'S SIGNATURE William S. Kinn		25c. DATE	

(M)

(1)

2882

2882

James

Robertson

10-25-1961

William Robert
Robertson
10-25-1961
2882-10-25-1961
2882-10-25-1961

William Robert
Robertson
10-25-1961
2882-10-25-1961

Robertson
10-25-1961
2882-10-25-1961

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted on the certificate. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13396
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13376

1. PLACE OF DEATH a. COUNTY Anne Arundel County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harwood	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The home of Mrs. Wm. Kirkpatrick, Harwood P. O., Anne Arundel County		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) THOMAS		4. DATE OF DEATH Month December Day 4, Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 57 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Blake		14. MOTHER'S MAIDEN NAME Kate Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) No		16. SOCIAL SECURITY NO. 315-16-1210	
17. INFORMANT Virian Holland Edgewater Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial	
19. WAS AUTOPSY PERFORMED? Partial YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE Howard G. Shaub EXAMINER'S NAME (Type) HOWARD G. SHAUB, M.D.		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-8-1961		22b. DATE THEREOF 12-8-1961	
22c. NAME OF CEMETERY OR CREMATORY Adams Chapel Bayard Md.		22d. LOCATION (City, town, or country) (State) Md.	
23. FUNERAL DIRECTOR William Reesett Anna Md.		24a. REC'D BY REGISTRAR DEC 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline		DATE DEC 7 '61	

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13397

13377

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>!</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Drive - Lake Shore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena X (Lake Shore)</u> d. STREET ADDRESS <u>Rt. 7 - Box #529 / Forest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>August F. Boblitz, Jr.</u> First Middle Last				4. DATE OF DEATH <u>December 2 1961</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>28 Nov - 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Lanham Co.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Boblitz</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>220-09-3522</u> 17. INFORMANT <u>Mrs. Emma C. Boblitz - Same as #2</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the right kidney</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with extensive metastases</u> DUE TO (c) <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1961</u> to <u>December 2, 1961</u> ; that (I) <u>(we)</u> last saw the deceased alive on <u>December 1, 1961</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. M. McLaughlin</u> M.D.				22b. DATE SIGNED <u>12/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-1 Dec - 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Mem. Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Green Belts, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				25. REC'D BY REGISTRAR DATE <u>DEC 7 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>				25c. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13897

(M)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "you", "I", and "the" are faintly visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 should be retained by the hospital or attending physician. IF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13398

Items 13 & 14 Film G302 12/15/61 jwk

13378

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Gambrills		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Dead on arrival) Anne Arundel General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Adam Middle BOSCHERT Last BOSCHERT			4. DATE OF DEATH Month December Day 5 Year 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 21, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Andrew Boschert			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mr. George Boschert			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Failure DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac Disease (c) 434		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) May		20g. (County) 1958		20h. (State) Dec.	
21. I certify that (I) (the informant) attended the deceased from May , 1958, to Dec. , 1961, that (I) (the informant) saw the deceased alive on Dec. , 1961, and that death occurred at 9:45 AM , from the causes and on the date stated above.					
22a. SIGNATURE Richard N. Peeler, M.D.		22b. DATE SIGNED 12/5/61		22c. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9th Dec. 1961		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Field	
23d. LOCATION (City, town or county) Millersville, Maryland		23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Thomas W. Singleton		24b. ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kram		25c. DATE DEC 11 '61			

200 Crain Highway

13383

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NAME: Arnold

ADDRESS:

(Lead on arrival)

NAME: Arnold General Hospital

DATE:

AGE: 35

January 21, 1963 75X3X

Blacksmith (Tol.)

217 1/2 N. 1st St.

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13399						13379					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
e. COUNTY			Anne Arundel			e. STATE			b. COUNTY		
			MARYLAND			Maryland			Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Annapolis				10 days		X Route 4 Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Anne Arundel General						1 Arnold md					
3. NAME OF DECEASED						4. DATE OF DEATH			5. AGE		
(Type or print)		First		Middle		Last		Month		Day	
		Nellie		M.		Brooks		Dec.		23	
										19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 15, 1889		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife						Md.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Unknown						Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia											
584X DUE TO (b) Acute Pancreatitis											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Cholelithiasis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Uremia; Arteriosclerotic hypertensive carido-vascular renal disease											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
Dr. Lionel Mapp						Crownsville State Hospital					
						Crownsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		12-26-61		Mt. Calvary Cem		Anne Arundel					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Chay O. Wilson						DEC 29 '61		Arthur L. Frank			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13400

13380

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2711 Winchester St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patience Brooks</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-81</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Sam Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Reed C. S. H.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-23-</u> 19 <u>61</u> , to <u>12-31-</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-31-</u> 19 <u>61</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Pope</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Int Auburn</u>			
23d. LOCATION (City, town or county) <u>Baltimore</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Horner</u>		24b. ADDRESS <u>512 Conwellman</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 4 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thane</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1898

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1, 2, 3, and 4 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13402 Inf. from birth certificate											
CERTIFICATE OF DEATH											
13381											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN lb 35 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Arnold						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS Joyce Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ellouise First Middle Last					4. DATE OF DEATH December 3 1961 Month Day Year						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1961		9. AGE (In years last birthday) yrs. 35 IF UNDER 1 YEAR Months Days Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Franklin Brown					14. MOTHER'S MAIDEN NAME Ellouise Day						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 778 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) X DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this person) attended the deceased from Dec. 3, 1961 to Dec. 3, 1961 , that (I) (was) last saw the deceased alive on Dec. 3, 1961 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE R. L. Richardson				M.D. 8:35 PM		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/4/61			
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.				22d. ADDRESS 110 Clay St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 6/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Int Calvary		23d. LOCATION (City, town or county) (State) Arnold Md					
24. FUNERAL DIRECTOR'S SIGNATURE Annie A. Johnson				ADDRESS Annapolis		25a. REC'D BY REGISTRAR DATE DEC 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13404
CERTIFICATE OF DEATH
13384

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> <u>ANNAPOLIS</u> <u>2 WKS.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PASADENA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GEN. HOSP.</u>				d. STREET ADDRESS <u>1 BOX 138 Rt. 10</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH R. BULL</u>		4. DATE OF DEATH <u>DEC. 30 1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 9 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>?</u>		Address <u>---</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, HYPOSTATIC</u> DUE TO (b) <u>FRACTURE, SUBCAPITAL, LEFT HIP</u> DUE TO (c) <u>DEHYDRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE SEVERE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>FELL & BROKE LEFT HIP</u>		20c. TIME OF INJURY Month, Day, Year <u>DEC. 15 1961</u>		20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>PASADENA MD.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 15 1961</u> to <u>DEC. 30 1961</u> that (I) (we) last saw the deceased alive on <u>DEC. 30 1961</u> , and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George Settle / G. L. Kison</u>		22b. DATE SIGNED <u>12-30-61</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE SETTLE</u>		22d. ADDRESS <u>ANNE ARUNDEL GEN. HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>1/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		24b. ADDRESS <u>4600 Liberty Hgts. Ave.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



Ellsworth Anatomical - 4000 Liberty Light, Ave.

Portland, Oregon

Baltimore, Maryland

Office of the

State of

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Department of

Public Health

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CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

Handwritten text, possibly a date or name, in the right margin.

Vertical text on the far right edge of the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13406
CERTIFICATE OF DEATH

Reg. Dist. No. 13386

1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>XGLEN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>E.</u> Last <u>CALTRIDER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	11. IF UNDER 24 HRS. Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Caltrider</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Schaeffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-28-7400 A</u>	
17. INFORMANT <u>Ethel E. Caltrider, 104 Summit Ave., Glen Burnie</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>60</u> , to <u>Sept. 25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept. 25, 1961</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u> M.D.		ADDRESS (Street, city or town, state) <u>2101 S. Ritchie Highway</u> DATE SIGNED <u>12/30/61</u>	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		<u>Glen Burnie, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn & Fleming, Inc.</u>		ADDRESS <u>1422 Light St.</u>	
24a. REC'D BY REGISTRAR <u>Jan 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TREATMENT OF EARTH

13-00

(M)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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13407

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13387

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Route 4 Box 85 B. Annapolis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>David D. Carr</i>		4. DATE OF DEATH <i>12 27 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-19-1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Carr</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Carr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Abner Spriggs R4 Box 85 B. Annapolis</i>	
17. INFORMANT <i>Abner Spriggs</i>		Address <i>R4 Box 85 B. Annapolis</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592x pneumonia, pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>chronic renal disease</i> DUE TO (c) <i>Interval BETWEEN ONSET AND DEATH 2 wks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>0</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-2-61</i> 19, to <i>12-27-61</i> 19, that (I) (we) last saw the deceased alive on <i>12-26-61</i> , and that death occurred at <i>12-27-61</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W. T. Allen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W. T. ALLEN</i>		22d. ADDRESS <i>612 Chestnut St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-31-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		23d. LOCATION (City, town, or county) <i>St. Margaret's Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>Jan 2 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>		25c. DATE <i>Jan 2 '62</i>	

13601

CERTIFICATE OF DEATH

13601

M

CERTIFICATE OF DEATH

Reg. Dist. No. 13388

13408

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FRANKLIN MANOR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>M.</u> Last <u>Coffman</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1872</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William RAMBLER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH KENNEDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>AGNES S. LOUGHRY</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>450.0</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 14, 1959</u> , to <u>Dec. 22, 1961</u> , that I last saw the deceased alive on <u>December 21, 1961</u> , and that death occurred at <u>12:40 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>12/22/61</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-24-61</u>		<u>RIVERVIEW</u>		<u>HUNTINGDON PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Ly...</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 26 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13409

13389

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>32 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#10 Greenway - Marley Park</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Marley Park)</u> d. STREET ADDRESS <u>#10 Greenway</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anne E. Colhouer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Twilight Inn</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			
13. FATHER'S NAME <u>Archibald Hullett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ford</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>213-22-7097</u>		17. INFORMANT <u>Mr. George W. Colhouer</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> <u>INTESTINAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA, COLON</u> DUE TO (c) <u>6 MOS.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> <u>1961</u> to <u>DEC. 13</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 11</u> <u>1961</u> , and that death occurred at <u>8</u> <u>M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Leon C. Perry,</u>		22b. DATE SIGNED <u>12-15-61</u>		22c. PHYSICIAN'S NAME (Type) <u> </u>			
22d. ADDRESS <u> </u>		22e. ADDRESS <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16th Dec. '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>			
23d. LOCATION (City, town or county) <u>Glen Burnie, Maryland</u>		23e. (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		24a. ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u> </u>			
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>DEC 18 '61</u>		25d. (State) <u> </u>			

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13410						13390					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Anne Arundel						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Hgts.						b. COUNTY Anne Arundel					
c. LENGTH OF STAY IN 1b 6 yrs						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Hgts.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 407 Doris Ave.						d. STREET ADDRESS 407 Doris Ave.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
MODESTA COSTA						Dec. 8, 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1896		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	
										11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Louisiana		
12. CITIZEN OF WHAT COUNTRY? U. S.											
13. FATHER'S NAME Joseph Costa						14. MOTHER'S MAIDEN NAME Mary Gagliano					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Salvatore Costa		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Thrombosis DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 2, 1959 to Dec 8, 1961 , that (I) (we) last saw the deceased alive on Dec 8, 1961 , and that death occurred at 10:05 AM , from the causes and on the date stated above.											
22a. SIGNATURE Benjamin Berdann M.D.											
22b. DATE SIGNED Dec. 9, 1961											
22c. PHYSICIAN'S NAME (Type) Benjamin Berdann M.D.											
22d. ADDRESS 5010 A. Gov. Ritchie Hwy, Balto 25, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Dec. 11, 1961											
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemen Cemetery											
23d. LOCATION (City, town or county) (State) Belair Rd. Baltimore, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gence ADDRESS 4001 Ritchie Hwy. (25)											
25a. REC'D BY REGISTRAR DEC 12 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13411

Item 14 Film 6303 12/22/61

13391

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 6 mos. 12 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester-Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Phillip St. Extension		3. NAME OF DECEASED (Type or print) First Middle Last Thomas Crossen			
4. DATE OF DEATH Month Day Year 12 11 19 61		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep.		8. DATE OF BIRTH 1898	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook's Helper		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Crossen		14. MOTHER'S MAIDEN NAME Celaine unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforating Duodenal Ulcer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Central Nervous System Syphilis		Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 5/29 1960 , to 12/11 1961 , that (I) (we) last saw the deceased alive on 12/11 1961 , and that death occurred at 6:15 P. M. from the causes and on the date stated above.		22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 12/12/61		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22d. ADDRESS Crownsville State Hospital, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-13-61		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Sweet		24b. ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 14 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas		25c. DATE DEC 14 '61	

UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **13392**

1. PLACE OF DEATH a. COUNTY AN CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY ANCO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRACY LANDING				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A O N - ANNIE REYNOLDS - GENERAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ronald Middle CROUCH Last CROUCH				4. DATE OF DEATH Month 12 Day 3 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-39	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	IF UNDER 24 HRS. Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY House Painting			
11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Carlyle Crouch				14. MOTHER'S MAIDEN NAME Mary Wolford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 170-32-2899			
17. INFORMANT Mrs. Carlyle Crouch, Slippery Rock, Pa.				Address Slippery Rock, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE INJURIES DUE TO 816X Conditions, if any, which gave rise to immediate cause (b) 816X (a), stating the underlying cause last. (c) 816X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 816X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury from auto - auto accident on 12/25/61			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Slippery Rock, Pa.				20f. (City or town) (County) (State) Slippery Rock, Pa.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. Linhart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/6/61			
22c. NAME OF CEMETERY OR CREMATORY West Sunbury Union Cem.				22d. LOCATION (City, town, or county) (State) Clay Township, Butler Co., Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				24. REC'D BY REGISTRAR DEC 6 '61			
ADDRESS Annapolis, Maryland				24b. REGISTRAR'S SIGNATURE William S. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

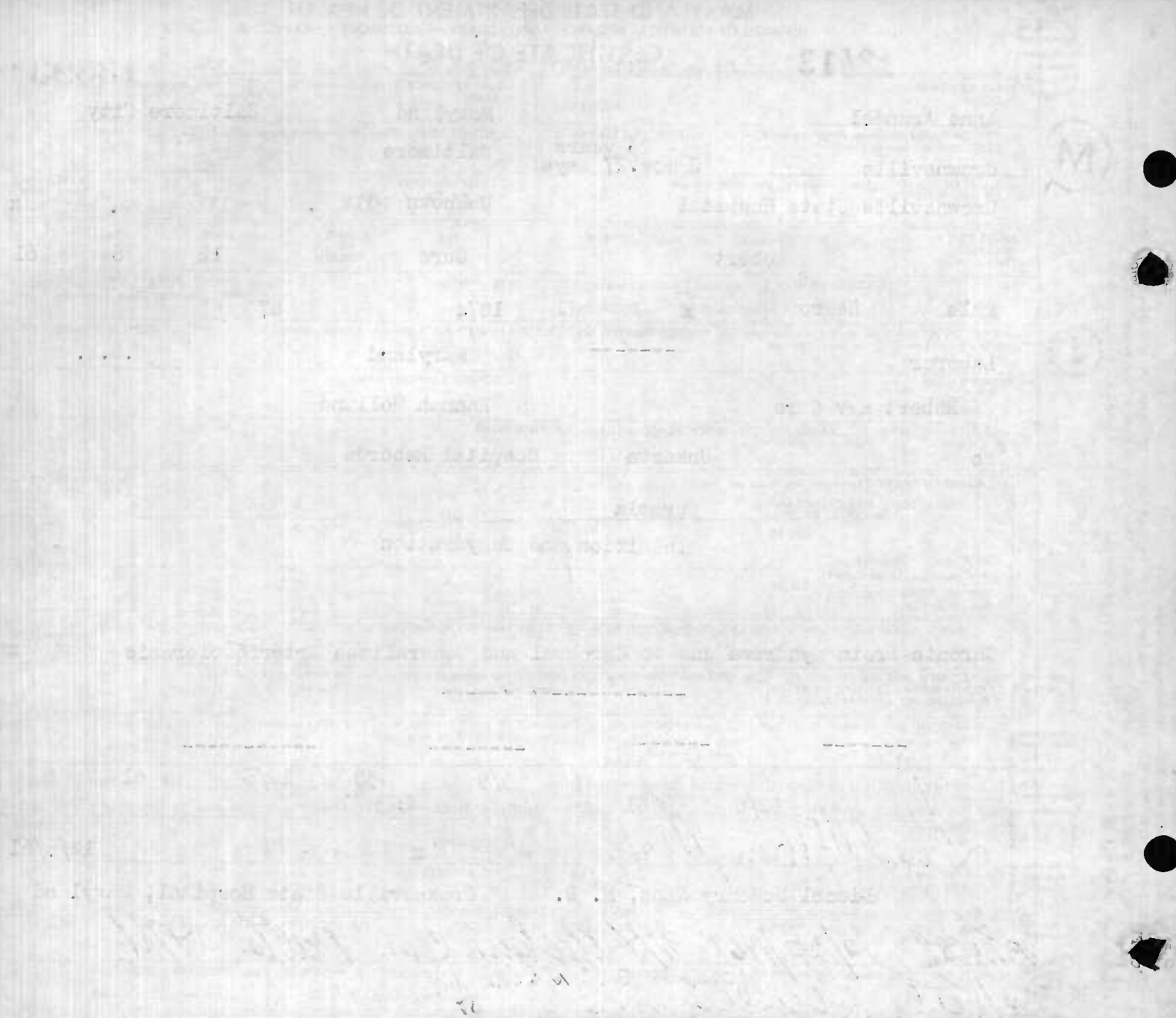
PHYSICIAN'S CERTIFICATE OF DEATH

Item 2 Film G30

12/27/61 - msk

43300

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 23 years 2 mos. 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown 1012 N. Carrollton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month 12 Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Robert Key Cure		14. MOTHER'S MAIDEN NAME Hannah Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 334X DUE TO Inanition and Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Cerebral and Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 3/9 19 38 , to 12/6 19 61 that (I) (we) last saw the deceased alive on 12/6 19 61 , and that death occurred at 225 M. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 12/6/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL - CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/20/1961	23c. NAME OF CEMETERY OR CREMATORY W. A. C. Cem.	23d. LOCATION (City, town, or county) (State) Balto. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Mr. R. L. Williams		25a. REC'D BY REGISTRAR DEC 20 '61	25b. REGISTRAR'S SIGNATURE Anthony S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13414 CERTIFICATE OF DEATH 13394															
1. PLACE OF DEATH e. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 239 Prince George St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles				First P.				Middle DALTON				Last DALTON			
4. DATE OF DEATH December 19 1961		Month December		Day 19		Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1909		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOUT				11. BIRTHPLACE (County & State, or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME CHARLES P. DALTON				14. MOTHER'S MAIDEN NAME Eric SINGLETON											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W W II				17. INFORMANT LUCILLE DALTON				Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 541.1 DUE TO Generalized peritonitis and aspiration of hemodigestive gastric content with large perforated duodenal ulcer with general peritonitis and massive gastric hemorrhage. 72 hours. 72 hours. DUE TO Cirrhosis of the liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the doctor) attended the deceased from Dec. 16, 1961 to Dec. 18, 1961 that (I) (we) saw the deceased alive on Dec. 18, 1961 , and that death occurred at 12:05 AM from the causes and on the date stated above. 22a. SIGNATURE Barber C. Palmer, Jr. M.D. 22b. DATE 12/19/61 22c. PHYSICIAN'S NAME (Type) Barber C. Palmer, M.D. 22d. ADDRESS 77 Franklin St., Annapolis, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-20-1961				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial				23d. LOCATION (City, town or county) (State) Annapolis Md			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Suss				ADDRESS Annapolis Md				25a. REC'D BY REGISTRAR DEC 22 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Krasa			

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and several other stamps

Stamps

Stamps

CHARLES F. Dwyer

Stamps

Stamps

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Dec. 18, 1901

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and several other stamps

Stamps

Stamps

CHARLES F. Dwyer

Stamps

Dec. 18, 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13415

CERTIFICATE OF DEATH

Reg. Dist. No. 13395

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port George G. Meade</u>		d. STREET ADDRESS <u>Qtrs # 1819-B Meade Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CINDY</u> Middle <u>L.</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Jan 58</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Davis</u>		14. MOTHER'S MAIDEN NAME <u>Anna Horwath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Father</u>		Address <u>Same as item 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>587.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cystic Fibrosis</u> DUE TO (c) <u>Congenital</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Dec</u> , 19 <u>61</u> , to <u>10 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 Dec</u> , 19 <u>61</u> , and that death occurred at <u>10:30 A.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sherman S. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kimbrough Army Hosp Ft Geo G. Meade, Md.</u>	
PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13416

CERTIFICATE OF DEATH

13396

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in b 8 mos. 4 years 28 days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 10717 Shantsberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nathan		First Nathan		Middle Davis		Last Davis		4. DATE OF DEATH Month 12		Day 16		Year 1961							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83		Days 16		IF UNDER 24 HRS. Hours 1961					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Clarksberg, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Rinaldo Davis						14. MOTHER'S MAIDEN NAME Minerva Snowden													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-20-9377				17. INFORMANT Hospital Records				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Fecal Impaction												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fecal Impaction												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----															
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State) -----							
21. I certify that (I) (this hospital) attended the deceased from 3/18 , 19 57 to 12/16 , 19 61 , that (I) (we) last saw the deceased alive on 12/16 , 19 61 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.																			
22a. SIGNATURE Hildegard Heard Reissman						M.D. Hildegard Heard Reissman, M. D.						22b. DATE SIGNED 12/18/61							
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.						22d. ADDRESS Crownsville State Hospital, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/21/61				23c. NAME OF CEMETERY OR CREMATORY Brewer Hill				23d. LOCATION (City, town or county) (State) Annapolis, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks, III						ADDRESS Annapolis, Maryland						25a. REC'D BY REGISTRAR DATE DEC 22 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13518

From [illegible]

to [illegible]

Subject: [illegible]

[illegible]

Date

[illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13397

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Arnold</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1 R. F. D.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Robert</i> Last <i>Daywalt</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>9</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Director of School for AA6 Md.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hagerstown Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Caroline S. Daywalt</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of prostate</i> DUE TO <i>metastatic to bone</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic to bone</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i> <i>6 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> 19 <i>61</i> , to <i>12-9-1961</i> , that (I) (we) last saw the deceased alive on <i>12-5-1961</i> , and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank M. Shipley</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>FRANK M. SHIPLEY</i>		22d. ADDRESS <i>Annapolis Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-12-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cashbury Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Arnold Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Julius M. Taylor Sons</i> ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 13 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13418

CERTIFICATE OF DEATH

Reg. Dist. No. 13398

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b birth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 9, box 71				d. STREET ADDRESS Rt. 9, box 71		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Franklin Middle DEAN Last Jr.				4. DATE OF DEATH Month December Day 3 Year 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-61	
9. AGE (In years last birthday) --- yrs.		IF UNDER 1 YEAR Months 5 Days 20		IF UNDER 24 HRS. Hours --- Min. ---			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)	
12. CITIZEN OF WHAT COUNTRY? -----							
13. FATHER'S NAME Franklin Dean Sr.				14. MOTHER'S MAIDEN NAME Alicetina Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----		17. INFORMANT Mother-same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3 , 19 61 , to present , 19 --- , that I last saw the deceased alive on --- , 19 --- , and that death occurred at 8.20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 425 S. Ritchie Hwy DATE SIGNED 3 Dec 1961							
ACTUAL SIGNATURE H. F. Manuzak				M.D. H. F. Manuzak, M.D.			
PHYSICIAN'S NAME (Type) H. F. Manuzak, M.D.				Glen Burnie, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/61		22c. NAME OF CEMETERY OR CREMATORY Magothy Cemetary		22d. LOCATION (City, town, or county) (State) Anns Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson				24a. REC'D BY REGISTRAR DEC 6 '61		24b. REGISTRAR'S SIGNATURE John S. Kline	

NOTE: The child was seen by Dr **Leipold** on **12-2-61**

2038225XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13399

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn, Md.</u> c. LENGTH OF STAY IN 1b <u>210 Hillcrest Ave.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>210 Hillcrest Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn, Md.</u> d. STREET ADDRESS <u>210 Hillcrest Ave.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leila M. Dean</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>St. Marys Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Owing Joy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Benson Dean</u>		Address <u>3608 Hineline Rd. #29</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> <u>451X</u> DUE TO (b) <u>ARTERIOSCLEROTIC AORTA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1, 1961</u> to <u>Dec 8, 1961</u>, that (I) (we) last saw the deceased alive on <u>Dec 8, 1961</u>, and that death occurred at <u>2:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Berdann</u>		22b. DATE SIGNED <u>Dec 8 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>		22d. ADDRESS <u>5010 A Ritchie Highway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/11/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>DEC 12 '61</u>	
ADDRESS <u>4107 Wilkens Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Tamm</u>	

VR A15 (4)
15M 9/60



Howard H. Hubbard 107 Wilkins Ave.

Box 1 12/1/57

Reception Company Chicago, Indiana

107 Wilkins Ave.

107 Wilkins Ave.

Box 1 12/1/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO NEARL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13420

CERTIFICATE OF DEATH

13400

Item 9 Film 6302 12/18/61 iwk

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaiah Dennis</u>		4. DATE OF DEATH Month Day Year <u>December 9 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 14, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Martha L. Prann</u>		Address <u>AA Co. D.P.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spasm of pharynx</u> (c) <u>cardiovascular disease with recurrent C.V.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Optic Atrophy - Hypertrophic Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-19-1960</u> to <u>12-9-1961</u> , that (I) (we) last saw the deceased alive on <u>12-9-1961</u> , and that death occurred about <u>8:00</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Pair</u>		22b. DATE SIGNED <u>12-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Pair - M.D.</u>		22d. ADDRESS <u>400 N. Carrollton Ave. Balt 23</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-13-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>		23d. LOCATION (City, town, or county) (State) <u>Shredyside Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna M. D.</u>	
25b. REGISTRAR'S SIGNATURE <u>William Reese</u>		DATE <u>DEC 13 '61</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13421

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13401

1. PLACE OF DEATH a. COUNTY <u>HA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>HA.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stem Buena</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stem Buena</u>		d. STREET ADDRESS <u>116 S. Meadow Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16 Meadow Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Carey Disney</u>		4. DATE OF DEATH Month Day Year <u>12 31 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/18</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BE P.D.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank</u>		14. MOTHER'S MAIDEN NAME <u>Helis Carey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) <u>Yes, Ind.</u>		16. SOCIAL SECURITY NO. <u>Family - Maine</u>	
17. INFORMANT <u>Family - Maine</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Liver Metastases from</u> (c) <u>Ca. of colon and rectum</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u> <u>4 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>Not</u> Not) attended the deceased from <u>March</u> 19 <u>61</u> to <u>Dec. 31</u> , 19 <u>61</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Dec. 31</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> p.m. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <u>C. Earl Hill</u>		22c. PHYSICIAN'S NAME (Type) <u>C. EARL HILL, M.D.</u>	
22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>		22e. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>	
22f. REGISTRAR'S SIGNATURE <u>Charles S. Frame</u>		22g. SIGNATURE <u>McLurey - 130 E To W Lk</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/4/61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Eden Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	

10001

10001

13 31 15 31 15 31

Francis Carey Stacey

18

Transcript - James
Harris (may)

Hepatic Cancer
Liver Metastases - from
Col. of colon and rectum
4 yrs.

None

March 49 - Dec. 31 51

Dec. 31 51

C. EARL HILL, M.D. 2108 Mountain Rd. Jackson, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO THE REGISTRY: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO THE GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13422

13402

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tucker Lane, Ednor P.O., Maryland	
c. LENGTH OF STAY IN 1b 8 y, 8 mo, 11 d.		d. STREET ADDRESS 1513-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Lillian Middle Dockett Last Dockett		4. DATE OF DEATH Month 12 Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1897
9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min. 64		IF UNDER 24 HRS. Months 64 Days 64 Hours 64 Min. 64
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Dockett		14. MOTHER'S MAIDEN NAME Annie Ford Dockett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002 DUE TO (c) 002 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15 1953 to 12/26 1961 , that (I) (we) last saw the deceased alive on 12/26 1961 , and that death occurred at 7:45 am from the causes and on the date stated above.			
22a. SIGNATURE Richard D. Reimann M.D.		22b. DATE 12/26/61	
22c. PHYSICIAN'S NAME (Type) Richard D. Reimann		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 12-29-61	
23c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY		23d. LOCATION (City, town, or county) (State) WATERBURY - A.A.Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. E. Nuckols		25a. REC'D BY REGISTRAR 43-45 north west	
25b. REGISTRAR'S SIGNATURE John S. H. H.		25c. DATE JAN 5 '62	

CERTIFICATE OF DEATH

1912

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Particular

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13423

13402

HOSPITAL [REDACTED] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 [REDACTED] be retained by the hospital or attending physician.

TUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours, after death.

10423

COMMUNIST PARTY

10423

Page 1

SECRET

CONFIDENTIAL

TO HOSPITAL: The law requires that the death certificate be completed within 72 hours after death. The certificate may be retained by the hospital or attending physician. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme pneumonia</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (doctors) attended the deceased from <u>Dec. 11, 1961</u> to <u>Dec. 11, 1961</u> , that (I) see last saw the deceased alive on <u>Dec. 11, 1961</u> , and that death occurred at <u>2:00 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert A. Riley, Jr., M.D.</u> M.D.				ATTENDING MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>12/11/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Riley, Jr., MD</u>				22d. ADDRESS <u>69 Franklin St., Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist</u>				23d. LOCATION (City, town or county) (State) <u>Davidsonville, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>35 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Edgewater</u> d. STREET ADDRESS <u>Rt-3, Box-189</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>DUCKETT</u> 4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1961</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 11, 1961</u> 9. AGE (In years last birthday) yrs. <u>35</u> IF UNDER 1 YEAR Months Days Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>James W. Duckett</u>			14. MOTHER'S MAIDEN NAME <u>Jean Isaac</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Hospital Records</u>			Address								

63

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VR A15 (4)
15M 9/60

1932

James A. Smith

James A. Smith

James A. Smith

James A. Smith

James A. Smith

James A. Smith

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James A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13425
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13405

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b 1 1/2 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3606 Ninth Street		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bank's Care Home				d. STREET ADDRESS Baltimore 25		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Howard Duffey				4. DATE OF DEATH Month Day Year December 24th, 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/84		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Duffey			14. MOTHER'S MAIDEN NAME Annette Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-7256		17. INFORMANT Address Mr. Elmer L. Duffey (son) Glen Burnie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic vascular diseases 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Glen Burnie		20g. (County) Prince Georges		20h. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from No attendance , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8 PM from the causes and on the date stated above.							
22a. SIGNATURE Gustave H. Faubert, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/61	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.				22d. ADDRESS Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		24a. ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR DEC 29 '61		25b. REGISTRAR'S SIGNATURE William L. Hines	

George J. Gonce

18482

CERTIFICATE OF DEATH

18482



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MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59

13101

CERTIFICATE OF DEATH

13101



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13427

CERTIFICATE OF DEATH

13407

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rt. 2 Box 355 Alpine Beach</i>		d. STREET ADDRESS <i>Rt. 2 Box 355 Alpine Beach</i>	
3. NAME OF DECEASED (Type or print) <i>Lewis (Louis) F. Fickus</i>		4. DATE OF DEATH <i>December 27, 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 11, 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mc Cormick Co.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>Frederick Fickus</i>		14. MOTHER'S MAIDEN NAME <i>Cunigunda Bayer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-01-8876</i>	17. INFORMANT <i>Mrs. Eleanor Fickus</i> Address <i>Same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarct</i> 42001 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Arterio-sclerosis</i> (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Myocardial infarct 1958, very extensive</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i> <i>10 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <i>(initials)</i> attended the deceased from <i>October 12/19 1961</i> to <i>12/27 1961</i> , that (I) <i>(initials)</i> last saw the deceased alive on <i>12/19 1961</i> , and that death occurred at <i>11:59 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>C. Earl Hill</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>C. EARL HILL</i>		22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/30/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>	
ADDRESS <i>5305 Harford Road #14</i>		DATE <i>DEC 29 '61</i>	



Pick 2

A-111 myocentral, 11-11-11

Anterior-spiral

Myocentral, 11-11-11, 11-11-11

CLEAR HILL

10000

RECEIVED IN THE DEPT.

10000

(M)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

MAILED IN

CERTIFICATE OF DEATH

13409

Reg. Dist. No.

13429

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANN ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOGM, Md.</u>		c. LENGTH OF STAY IN TB <u>4 Wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBROUGH ARMY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLAHERTY, JOSEPH F</u>		4. DATE OF DEATH <u>12 17 19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 1, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph FLAHERTY</u>		14. MOTHER'S MAIDEN NAME <u>MEANY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>MRS A POWELL, 116 FURNIEA DR, GLENBURNIE</u>	
17. INFORMANT Address <u>MRS A POWELL, 116 FURNIEA DR, GLENBURNIE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
420.1 DUE TO (b) <u>hypertensive</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>poss. myocardial infarct (1947)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>left sided parietal fracture</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Dec 1961</u> to <u>17 Dec 1961</u> , that I last saw the deceased alive on <u>17 Dec 1961</u> , and that death occurred at <u>14:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman I Rosenberg</u>		ADDRESS (Street, city or town, state) <u>KIMBROUGH ARMY HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN I ROSENBERG FT. GEORGE G. MEADE, MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Akron Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hubbard</u>		ADDRESS <u>4107 WILLIAMS AVE</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 be retained in the hospital or attending physician.
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

13430

14651

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u>		2. USUAL RESIDENCE (Place deceased lived. If Institution: Residence before admission) a. STATE <u>MARY</u> COUNTY <u>2ND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>4 Mon - 15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville - State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>91665</u> Last <u>91665</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1919</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NORTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia due to gangrenous bed</u> <u>702.0</u> DUE TO <u>SORES.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2. Old Subdural - Nematoma -</u> DUE TO (c) <u>3. Multiple - fracture - ribs - old.</u> INTERVAL BETWEEN ONSET AND DEATH <u>7-6-61</u> <u>To</u> <u>12-25-61</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen - fell on - was pushed out of 3rd floor window</u>	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u>7-6-61 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Baltimore Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>12/26/61</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/3/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hospital Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Crownsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. ...</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '62</u>	
ADDRESS <u>Crownsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MISSOURI STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN EDWARD DOWD		2. SEX Male	
3. AGE 34		4. DATE OF DEATH 12-10-1917	
5. PLACE OF DEATH St. Louis, Mo.		6. OCCASION OF DEATH Heart Disease	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural	
9. SIGNATURE OF EXAMINER W. H. [Signature]		10. SIGNATURE OF ATTENDING PHYSICIAN [Signature]	
11. SIGNATURE OF WITNESSES [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF JURY [Signature]		14. SIGNATURE OF JUDGE [Signature]	
15. SIGNATURE OF CLERK [Signature]		16. SIGNATURE OF [Other Official] [Signature]	



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13431

13410

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater d. STREET ADDRESS Muddy Creek Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Eva Augusta Gross			4. DATE OF DEATH Month Day Year 12 14 19 61		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 30, 1897		9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Sharps		14. MOTHER'S MAIDEN NAME Louise Moulden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Gladys Neal, Edgewater, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular Renal Disease (a), stating the underlying cause last. (c) Arteriosclerosis - Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Hypostatic Pneumonia, Decubitus Ulcers					
INTERVAL BETWEEN ONSET AND DEATH 8 days 15 years 15 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1959 to Dec. 14, 1961 , that (I) (we) last saw the deceased alive on Dec. 14, 1961 and that death occurred at 400 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE SIGNED 12/14/61		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22d. ADDRESS 20 Dean Street, Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Dec 17 1961		23c. NAME OF CEMETERY OR CREMATORY Adams Chapel	
23d. LOCATION (City, town or county) Bayard Rd.		23e. (State) Mt. Zion Md			
24. FUNERAL DIRECTOR'S SIGNATURE T A Harkstey + Son		24a. ADDRESS Galesville Md		25a. REC'D BY REGISTRAR DEC 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw					

VR A15 (4)
15M 9/60

18581

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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12432

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13411

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 yrs 13 yrs 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 94 Clay St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice		Middle		Last Hall		4. DATE OF DEATH Month 12 Day 22 Year 19 61	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900	
9. AGE (In years lost birthday) 61		IF UNDER 1 YEAR Months 12 Days 22 Hours 19 Min. 61		IF UNDER 24 HRS. Months 12 Days 22 Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Matilda Dennis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Dehydration & Inanition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Syphilis of the Central Nervous System		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/3 19 48 to 12/22 19 61 , that (I) (we) last saw the deceased alive on 12/22 19 61 , and that death occurred at M , from the causes and on the date stated above.		22a. SIGNATURE Lionel McHenry Mapp		22b. DATE 12/22/61		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-24-61		23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION (City, town, or county) (State) annapolis md	
24. FUNERAL DIRECTOR'S SIGNATURE CHARLES E. HICKS III		ADDRESS ANNAPOLIS-MARYLAND		25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Charles E. Hicks	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13412**

13433

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G Meade		c. LENGTH OF STAY IN 1b Unk	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kimbrough Army Hospital		d. STREET ADDRESS 1617C Forrest Ave	
3. NAME OF DECEASED (Type or print) First Mary Middle Katherine Last Harrell		4. DATE OF DEATH Month December Day 28 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 December 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months 15 Days 4 Hours 15 Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Harrell Jr		14. MOTHER'S MAIDEN NAME Mary N. Graham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mother		Address See item 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 4Hrs 15 Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 00 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 December 19 61 , to 28 December 19 61 , that I last saw the deceased alive on 28 December 19 61 , and that death occurred at 1115 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kimbrough Army Hospital Ft G G Meade, Md DATE SIGNED 28 Dec 1961			
ACTUAL SIGNATURE Max W. Bloomberg		M.D. Kimbrough Army Hospital Ft G G Meade, Md	
PHYSICIAN'S NAME (Type) MAX W. BLOOMBERG, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-62	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat-Cem	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Choy A. Wilson		24a. REC'D BY REGISTRAR DATE JAN 5 '62	24b. REGISTRAR'S SIGNATURE Christina S. Kraus

— 2050253020

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13434

13413

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>827 West St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Leon</u> HARRIS		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 5, 1905</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi Cabs</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland A.A.Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>William Harris</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Gallaway</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-16-2694</u>				17. INFORMANT <u>Martha Tyler</u> Address <u>827 West St. Annapolis, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pulmonary Embolism (Multiple)</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertensive Cardin</u> DUE TO (c) <u>Coronary disease</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 28, 1961</u> to <u>Dec. 28, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec. 28, 1961</u> and that death occurred at <u>8:40 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>R. L. Richardson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>						22d. ADDRESS <u>110 Clay St., Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 1-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) <u>Annapolis, Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>						ADDRESS <u>Annapolis, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1833



1833

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> <u>MARYLAND</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs - MD.</u> <u>15X'2</u> d. STREET ADDRESS _____																							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis - MD.</u>												c. LENGTH OF STAY IN 1b _____																							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. Anne Mewdel. General.</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Tripp</u> Last <u>HEMPHILL</u>												4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1961</u>																							
5. SEX <u>M</u>				6. COLOR OR RACE <u>W.</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>3-1-19.</u>				9. AGE (In years last birthday) <u>42</u> yrs.				IF UNDER 1 YEAR Months _____ Days _____				IF UNDER 24 HRS. Hours _____ Min. _____											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive States Marine Steamship Line</u>								10b. KIND OF BUSINESS OR INDUSTRY _____								11. BIRTHPLACE (State or foreign country) <u>New York City</u>								12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Clifford Hemphill</u>												14. MOTHER'S MAIDEN NAME <u>Mary G. Tripp</u>																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____												16. SOCIAL SECURITY NO. _____												17. INFORMANT <u>Julian Hemphill</u> Address <u>99 Wall St New York City</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>Cardiac</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>																																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____																							
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>								20d. INJURY OCCURRED _____ While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____								20f. (City or town) _____ (County) _____ (State) _____															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from _____ Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER _____ M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-2-61.</u> Address (Street, city, town, or county) _____																																			
ACTUAL SIGNATURE <u>[Signature]</u>												EXAMINER'S NAME (Type) <u>E. Linhardt.</u>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>Dec 5th 1961</u>								22c. NAME OF CEMETERY OR CREMATORY <u>Holleret Memorial</u>								22d. LOCATION (City, town, or country) <u>Annapolis</u> (State) <u>MD</u>											
23. FUNERAL DIRECTOR <u>John M. Saylor Sons</u> ADDRESS <u>Annapolis Md</u>												24a. REC'D BY REGISTRAR <u>DEC 6 '61</u> DATE _____												24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>											

ARMY AND NAVY DEPARTMENT OF HEALTH

M



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13437

13417

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>H.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2 Box 547</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>KLEIN</u> Last <u>HUMPLE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1869</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL AYERS</u>				14. MOTHER'S MAIDEN NAME <u>KATRIKA COOPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>FAMILY</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>1961</u> 19, that (I) (we) lost saw the deceased alive on <u>12-10-1961</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Hahn</u>				22b. DATE SIGNED <u>12-11-61</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. HAHN</u>	
22d. ADDRESS <u>RITCHIE HWY - SEVERNA PARK</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barancko - Severna Park, Md</u>				25a. REC'D BY REGISTRAR <u>DEC 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

(M)

13437

CERTIFICATE OF DEATH

13437

SHARLET AYERS
KATIKIA
Name

GENERALIZED DISTAL SYMPLECTIC

1952

DATE
HANK

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13438						13418					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Anne Arundle</i> MARYLAND						a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Park</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore</i>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <i>6034 Bellegrove Rd.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13. NAME OF DECEASED (Type or print) <i>ANNIE LEE JOHNSON</i>						4. DATE OF DEATH <i>Dec 7 - 1961</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June-19-1904</i>		9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Suffolk Va.</i>		
13. FATHER'S NAME <i>Ed. White-Willie</i>						14. MOTHER'S MAIDEN NAME <i>Mary L. Lawrence</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT <i>ANnette J. HANKINS</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AC CEREBRAL HEMORRHAGE</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> (e), stating the underlying cause last. (c) <i>DISEASE</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>DIABETES MELLITUS</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/9/1958</i> to <i>12/7/1961</i> , that (I) (we) last saw the deceased alive on <i>10/10/1961</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>John Straxton Jr.</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>JOHN STRAXTON JR.</i>						22d. ADDRESS <i>922 S. SHARP ST.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-11-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore Md</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chas O. Wilson</i> ADDRESS <i>1000 Sontley Ave</i>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>			
						DATE <i>DEC 13 '61</i>					

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1945

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Willie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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X
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GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13439
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12/19/61 iwk

13419

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 95 Spencer Rd		d. STREET ADDRESS Box 95 Spencer Rd	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY JOHNSON		4. DATE OF DEATH Month 12 Day 12 Year 1961	
5. SEX MALE	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1885
9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) M.A. Co MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Johnson		14. MOTHER'S MAIDEN NAME REBECCA unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. REBECCA JOHNSON - MARLEY MD	
17. INFORMANT Address REBECCA JOHNSON - MARLEY MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Several Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-27-1961 to 12-12-1961 , that (I) (we) last saw the deceased alive on 12-11-1961 , and that death occurred at 1204 M, from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Hunt		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD H. HUNT		22d. ADDRESS 100 Cherry Lane, Glen Burnie, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/1961	
23c. NAME OF CEMETERY OR CREMATORY Hales A.F. Church		23d. LOCATION (City, town, or county) (State) Solley - A.A. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays ADDRESS 638 N. Gilmor St BALTO-17-MD		25a. REC'D BY REGISTRAR DATE DEC 14 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Turner	

Runia 12/1/51 - 1000 m

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13440				CERTIFICATE OF DEATH				13420			
Item 14 Film G304 1/2/62 iwk											
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville, Md</i>				c. LENGTH OF STAY IN b <i>5 mo, 1 day?</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hospital</i>				d. STREET ADDRESS <i>25 S. Bernice Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nora</i> Middle <i>Ann</i> Last <i>Joiner</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>1961</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>unknown</i>		9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>				11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				13. FATHER'S NAME <i>Willie Eugene</i>				14. MOTHER'S MAIDEN NAME <i>Frances unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> (If yes give number of service)				16. SOCIAL SECURITY NO. <i>unknown</i>				17. INFORMANT Address <i>Hospital Records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (b) <i>Generalized arteriosclerosis</i> (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension - Senile Dementia</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> 19 <i>61</i> to <i>12/16</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> 19 <i>61</i> , and that death occurred at <i>4:50 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr. L. Whit</i>				22b. DATE SIGNED <i>12/17/61</i>				22c. PHYSICIAN'S NAME (Type) <i>Dr. L. Whit</i>			
22d. ADDRESS <i>Crownsville, Md</i>				22e. REC'D BY REGISTRAR <i>DEC 22 '61</i>				22f. REGISTRAR'S SIGNATURE <i>William S. Peters</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>12-20-61</i>				23c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary Cem</i>			
23d. LOCATION (City, town or county) <i>A.A. Co</i>				23e. (State) <i>Md</i>				23f. REGISTRAR'S SIGNATURE <i>William S. Peters</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Rayner Sanders</i>				24a. ADDRESS <i>217 E. Preston St</i>				24b. DATE <i>DEC 22 '61</i>			

1940

1940

W. H. Hines

W. H. Hines

Boatman

Boatman

Cornville, N.H.

Cornville State Hospital

22 & 23rd St.

X

James

James

James

F

U

X

James

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

W. H. Hines

X

W. H. Hines

W. H. Hines

Cornville, N.H.

Cornville, N.H.

W. H. Hines

W. H. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained in the hospital or attending physician's office for 10 years. It should be filed in the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

Page 4

24 hours after

death

in the funeral director's

office

pages 1 and 2 should be filed with

the State Board of Health

prior to burial, cremation, or removal,

and in any event, within 72 hours after death.

page 3 should be detached for use as the burial-transit permit.

Then please remove carbon papers.

Pages 1 and 2 should be filed with

the State Board of Health

13441

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13421

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 ye, 7 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 85 Northwest Str.	
3. NAME OF DECEASED (Type or print) First Florence Middle Jones Last Jones		4. DATE OF DEATH Month 12 Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/1907
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Lewis Hoshia		14. MOTHER'S MAIDEN NAME Unknown Ella Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address Apex Brown River Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/28 19 57 , to 12/28 19 61 , that (I) (we) last saw the deceased alive on 12/28 19 61 , and that death occurred at 5:10am from the causes and on the date stated above.			
22a. SIGNATURE Hildegarde Reim M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12/28/61	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmann		22b. DATE SIGNED 12/28/61	
22d. ADDRESS Crownsville State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-31-1961		23b. DATE THEREOF 12-31-1961	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hall		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE William Geese, W-Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 2 '62	
ADDRESS William Geese, W-Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13442

CERTIFICATE OF DEATH

Reg. Dist. No. 13422

1. PLACE OF DEATH a. COUNTY Lothian, A.A. Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Lothian Md. b. COUNTY A.A Co. Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOTHIAN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LOTHIAN	
d. NAME OF HOSPITAL (If not in hospital, give street address) Folling House Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle MAY Last WIER		4. DATE OF DEATH Month Dec. Day 8 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1872
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Joseph Wier		14. MOTHER'S MAIDEN NAME Sallie Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nellie Jones Address Lothian, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Dec. 8 , 19 61 , that I last saw the deceased alive on Dec. 8 , 19 61 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Emily H. Wilson M.D.			
PHYSICIAN'S NAME (Type) Emily H. Wilson M.D. Lothian Anne Arundel Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		12-11-61	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Mt. Zion		Mt. Zion Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 13 '61	
24b. REGISTRAR'S SIGNATURE John M. Taylor			

CERTIFICATE OF DEATH

1964

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "65"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "10/15/1898"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. RACE [Faint text, possibly "White"]</p>	
<p>7. OCCUPATION [Faint text, possibly "Retired"]</p>		<p>8. MARITAL STATUS [Faint text, possibly "Married"]</p>	
<p>9. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>10. MANNER OF DEATH [Faint text, possibly "Natural"]</p>	
<p>11. DATE OF DEATH [Faint text, possibly "11/1/1964"]</p>		<p>12. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>	
<p>13. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]</p>	
<p>15. SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]</p>		<p>16. SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13444

13424

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 yrs. 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Paper Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		1939-2	
3. NAME OF DECEASED (Type or print) First Stanley		Middle Jones		Last Jones		4. DATE OF DEATH Month 12		Day 21	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1877		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months 12	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus - Arteriosclerotic Cardiovascular Disease - Mental Deficiency		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/18 to 12/21 , that (I) (we) lost the deceased on 12/21 , 19 61 , and that death occurred on 12/21 at 6:55 a. M., from the causes and on the date stated above.		22a. SIGNATURE Hilda Reissmann		22b. DATE 12/21/61		22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmann		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/3/61		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) Balto. Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Bede, Jr. Anna, Md.		25a. REC'D BY REGISTRAR DEC 29 '61		25b. REGISTRAR'S SIGNATURE Conrad E. Hanna		25c. DATE DEC 29 '61		25d. SIGNATURE	

(A)

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13425

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY in 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tracey's Landing		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) VIRGINIA		First		Middle		Last LEE Jones		DATE OF DEATH 12		Month 17		Day 19		Year 61									
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-61		9. AGE (In years last birthday) 2 1/2		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Calv. Co., Md.				12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME Melvin Jones						14. MOTHER'S MAIDEN NAME Ruth Creek																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give word or dates of service)				17. INFORMANT				Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Otitis Media DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Russell S. Fisher				M.D. RUSSELL S. FISHER, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-17-61			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-19-61				22c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem.				22d. LOCATION (City, town, or county) Mt. Kendree, Md.				22e. (State) MD							
23. FUNERAL DIRECTOR Leroy E. Berry - Huntingtown, Md.				ADDRESS				24a. REC'D BY REGISTRAR DEC 21 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kline											

206/4235XV5

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office for a period of 10 days after which it must be forwarded to the Registrar. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13426

1. PLACE OF DEATH a. COUNTY <u>Q. Q.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. A. General</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Q. Q.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1208 Brushers St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F.</u> Last <u>Heckler</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>1st</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10 - 1923</u> 9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A. Power Plant</u> 11. BIRTHPLACE (State or foreign country) <u>Phila Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Harry Heckler</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II - Korean</u>		16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Mrs Daisy M. Heckler</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan 1959</u> to <u>1 DEC 1961</u> , that (I) (we) last saw the deceased alive on <u>27 Nov 1961</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward Beck</u> M.D.		22b. DATE SIGNED <u>DEC 6 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor SWS</u> ADDRESS <u>Annapolis Md</u>		25a. RECEIVED BY REGISTRAR <u>DEC 6 1961</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Caroline S. Harris</u>	

1944

CERTIFICATE OF DEATH

1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13447													
13427													
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Rachael SURGEON KENT						4. DATE OF DEATH Month Day Year December 24 1961							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Richardson Grayson						14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. UNKNOWN						17. INFORMANT Louise Wise - 107 Larue Square - Balt Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Congestive Heart Failure (c) Generalized Arteriosclerosis DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 48 hrs. 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec. 23, 1961 , to Dec. 24, 1961 , that (I) (X) saw the deceased alive on Dec. 24, 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.													
22a. SIGNATURE Theodore H. Johnson						22b. DATE SIGNED 12/28/61							
22c. PHYSICIAN'S NAME (Type) Theodore H. Johnson, M. D.						22d. ADDRESS 37 Calvert St., Annapolis, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-28-61		23c. NAME OF CEMETERY OR CREMATORY ANNAPOLIS Neck		23d. LOCATION (City, town or county) (State) ANNAPOLIS - Md.							
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks						25a. REC'D BY REGISTRAR JAN 5 '62						25b. REGISTRAR'S SIGNATURE Arthur S. Hester	



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Richardson Grayson

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Unknown source - 102 Lafayette St. N.Y.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13448

13428

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade				c. LENGTH OF STAY IN 1b Unk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kimbrough Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Louie Last Kiser				4. DATE OF DEATH Month December Day 28 Year 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 May 1924	
9. AGE (In years lost birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Grover Clevelan Kiser				14. MOTHER'S MAIDEN NAME Deceased			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) July 1944 to date				16. SOCIAL SECURITY NO. 245-18-0834		17. INFORMANT Personnel Records US Army Ft Geo G Meade, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 Dec 1961 to 28 Dec 1961 , that (I) was lost saw the deceased alive on 28 Dec 1961 , and that death occurred at 0538 A. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Sherman S. Robinson</i>				22b. DATE SIGNED 28 December 1961		22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, CAPT, MC	
22d. ADDRESS Kimbrough Army Hospital Ft Geo G Meade, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington - Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Carl B. Womack</i>				25a. REC'D BY REGISTRAR JAN 3 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiser</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS - BOSTON
CERTIFICATE OF DEATH

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MADE IN U.S.A.
CHIEF CLERK

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

12/29/61

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12/30/61

Lee Funeral Home

Washington D.C.

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13449

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Owen		First		Middle		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-81	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	
10b. KIND OF BUSINESS OR INDUSTRY Holmes Bakery		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John O. Layton				14. MOTHER'S MAIDEN NAME Rose Gates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 578-09-6606				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, massive 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Excessive anticoagulant therapy and DUE TO Cerebral atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 8 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1961 to 12/29/61 , 19 61 , that (I) (we) last saw the deceased alive on 12/29/61 , 19 61 , and that death occurred 4P M, from the causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith				22b. DATE SIGNED 12/30/61		22c. PHYSICIAN'S NAME (Type) Dr. Willard Smith	
22d. ADDRESS Shadyside, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				25a. REC'D BY REGISTRAR JAN 5 62		25b. REGISTRAR'S SIGNATURE Anthony L. Harris	

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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 1 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13450					13430				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Anne Arundel		MARYLAND			Florida		✓		
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Annapolis		Coral Gables			304 Majorka Avenue		48X-3		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)									
Anne Arundel General Hospital									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
Marcel		L.		Le Blanc		December 2		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/24/07		54 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Not working		ADVERTISING NEWS PAPERS		NEW ROCHELLE NY					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
GEORGE L. LE BLANC					VIOLET BARNETT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
YES WW2									
17. INFORMANT					Address				
OFFELIA S. LE BLANC									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								3 sec	
IMMEDIATE CAUSE (a) Hepatic Insufficiency									
581.1 DUE TO									
(b) Laennec's carcinoma of liver								2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from 11/26, 1961, to 12/2, 1961, that (I) (we) last saw the deceased alive on 12/2, 1961, and that death occurred at 2:15 PM, from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
Richard N. Peeler M.D.					22d. ADDRESS				
22c. PHYSICIAN'S NAME (Type)					121 Cathedral Street Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		12/5/61		HOLY ROOD COM.		WESTBURY NY			
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOHN M. TAYLOR-SONS ANNAPOLIS MD.					DATE DEC 5 '61		Charles E. Hume		

(M)

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Wm. (Armed) General Hospital

304 No. 101st Avenue

Wm. (Armed)

Wm. (Armed)

Wm. (Armed)

Wm. (Armed) 13430

Wm. (Armed) 13430

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13451

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1 & 2 Film G302 12/12/61 iwk

13432

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in lb 11/9/61 to 12/4/61		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur		4. DATE OF DEATH 12		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-01		9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 12 Days 4 Year 1961			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George McEwen		14. MOTHER'S MAIDEN NAME Julia Buford		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.			
17. INFORMANT Emmale McEwen		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-4-61		ACTUAL SIGNATURE Russell S. Fisher		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-1961	
22c. NAME OF CEMETERY OR CREMATORY Annapolis Neck		22d. LOCATION (City, town, or country) (State) Annapolis Md.		24b. REC'D BY REGISTRAR DEC 5 '61		24c. REGISTRAR'S SIGNATURE William Beese		24d. REGISTRAR'S SIGNATURE Anna McEwen		24e. REGISTRAR'S SIGNATURE Anna McEwen		24f. REGISTRAR'S SIGNATURE Anna McEwen		24g. REGISTRAR'S SIGNATURE Anna McEwen			

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13-1-61

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13452

Items 8 & 9 Film 9305 1/10/62 jmk

13433

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb 34 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS 115 Clay Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Clay Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM McPHERSON				4. DATE OF DEATH Month Dec Day 24 Year 19 61			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20-1886		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Attendant Retired Academy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander McPherson				14. MOTHER'S MAIDEN NAME Harriett Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Hattie McPherson- 115 Clay St. Annapolis-Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral Hemorrhage due to DUE TO (b) Arteriosclerotic Hypertensive Vascular Disease DUE TO (c) 5 days Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State) Dec 19 1959 to Dec 24 1961	
21. I certify that (I) (this hospital) attended the deceased from Dec 19 1959 to Dec 24 1961 , that (I) (we) last saw the deceased alive on Dec 24 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE R.L. Richardson				22b. DATE SIGNED 12/26/61		22c. PHYSICIAN'S NAME (Type) R.L. Richardson	
22d. ADDRESS 110 Clay Street-Annapolis, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-27-61		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 Annapolis, Maryland				25a. REC'D BY REGISTRAR JAN 5 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13434

1. PLACE OF DEATH a. COUNTY Anne Arundel County, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Odenton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OTTO		First Middle Last MEYER		4. DATE OF DEATH December 11, 19 61		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 6, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape		10b. KIND OF BUSINESS OR INDUSTRY Gardener	
11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Johann Meyer		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Hospital records		Address Anne Arundel Co Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) partial						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by motor car.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Dec. 11, 19 61		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Conways, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Howard G. Shaub		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/12/61	
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 15, 1961	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.		23. FUNERAL DIRECTOR F Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 18 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna		VS. A15ME SM 9/60			

10453

IN THE

U.S. DISTRICT COURT

Plaintiff

vs.

Defendant

Case No. 10453

1

John

Smith

Plaintiff

vs.

John

Smith

Defendant

Case No. 10453

U.S. DISTRICT COURT

Plaintiff

vs.

John

Smith

Defendant

Case No. 10453

U.S. DISTRICT COURT

Plaintiff

vs.

John

Smith

Defendant

Case No. 10453

U.S. DISTRICT COURT

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park, Md.		c. LENGTH OF STAY in 1b 3 1/2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 518, Jumper Hole Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Moore		4. DATE OF DEATH Month Day Year Dec. 5, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/96
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hardware Store Clerk	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Morris Moore		14. MOTHER'S MAIDEN NAME ? Catherine (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-2704	
17. INFORMANT Mrs. Hazel M. Talheimer (stepdaughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Glen Burnie, DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 12/6/61 Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7th Dec. 61	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or country) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR Richard V. Dingle		24a. REC'D BY REGISTRAR DEC 11 1961 24b. REGISTRAR'S SIGNATURE Glen Burnie, Md.	

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1315

CERTIFICATE OF DEATH

1315

CHIEF OF BUREAU

DEATH

NAME OF DECEASED
JAMES J. JONES

RESIDENCE
1234 5th Ave.
New York, N.Y.

DATE OF DEATH
JAN 15 1915
PLACE OF DEATH
New York, N.Y.
CAUSE OF DEATH
DISEASE OF THE HEART
AGE
45
SEX
M
OCCUPATION
Clerk
EDUCATION
High School
MARRIAGE
Married
SPOUSE
Mary J. Jones
BORN
JAN 1 1870
DIED
JAN 15 1915
BURIED
Catholics
Funeral Home
J. J. Jones & Co.
1234 5th Ave.
New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13456

CERTIFICATE OF DEATH

Reg. Dist. No. 13437

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN 1b 3 Hrs 44 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kimbrough Army Hospital		d. STREET ADDRESS Box 133A	
3. NAME OF DECEASED (Type or print) First NOT NAMED Middle Last Nail		4. DATE OF DEATH Month December Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Dec 1961
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 3 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fred H. Nail	
14. MOTHER'S MAIDEN NAME Shirley Faye Phelps		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Mother Address Same as Item 2D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 750 X DUE TO Anencephaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Hrs 44 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 December, 19 61 to 20 December, 19 61, that I last saw the deceased alive on 20 December, 19 61, and that death occurred at 0830A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 20 Dec 61	
ACTUAL SIGNATURE Stuart Bernstein Capt		M.D. Kimbrough Army Hospital FGGM, MD	
PHYSICIAN'S NAME (Type) STUART BERNSTEIN, CAPTAIN, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 20 Dec 61	
22c. NAME OF CEMETERY OR CREMATORY KIMBROUGH ARMY HOSPITAL		22d. LOCATION (City, town, or county) (State) Ft Geo G. Meade, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Steeger Mt.		ADDRESS 24a. REC'D BY REGISTRAR DEC 22 61	
24b. REGISTRAR'S SIGNATURE Curtis S. Hanna			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13457

CERTIFICATE OF DEATH

13438

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Annapolis d. STREET ADDRESS Rt-1, Box-321 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) BABY BOY NEWQUIST		4. DATE OF DEATH Month December Day 15 Year 19 61.		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1961		9. AGE (In years last birthday) yrs. 4 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stanley Arthur Newquist, Jr.						14. MOTHER'S MAIDEN NAME Patricia June Seger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. Hospital records.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity 776X DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) who attended the deceased from Dec. 15, 1961 to Dec. 15, 1961 that (I) was saw the deceased alive on Dec. 15, 1961 , and that death occurred at 8:50 AM from the causes and on the date stated above.															
22a. SIGNATURE 						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/61							
22c. PHYSICIAN'S NAME (Type) Niel H. Sims						22d. ADDRESS 95 Cathedral St., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 18, 61		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City, town or county) Annapolis, Maryland (State)					
24. FUNERAL DIRECTOR'S SIGNATURE 						25a. REC'D BY REGISTRAR DATE DEC 19 '61		25b. REGISTRAR'S SIGNATURE 							

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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be retained by the hospital or attending physician.
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13458

CERTIFICATE OF DEATH

13439

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>600 PARKWOOD AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Jennie GILES NOBLE</u>			4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1961</u>		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 12, 1879</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Giles</u> 14. MOTHER'S MAIDEN NAME <u>Lillian Vermillion</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Mrs. BERTRAM E. SPRIGGS</u> Address <u> </u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arterio-sclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peritonitis secondary to strangulated femoral hernia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u>		
21. I certify that (I) (if deceased) attended the deceased from <u>Nov. 18, 1961</u> to <u>Dec. 6, 1961</u> , that (I) (if not) last saw the deceased alive on <u>Dec. 6, 1961</u> , and that death occurred at <u>4:40 AM</u> on <u>Dec. 6, 1961</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>G. Church</u> 22b. DATE SIGNED <u>12/7/61</u>			22c. PHYSICIAN'S NAME (Type) <u>GEOFFREY CHURCH</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Margaret's Cent</u>	
23d. LOCATION (City, town or county) <u>Annapolis</u> (State) <u>MD</u>		25a. REC'D BY REGISTRAR <u>DEC 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> 24b. ADDRESS <u>Annapolis, Md</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13459

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

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FOR STATE
HEALTH DEPT.
VI

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is not necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel County, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 109 Monticello Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 Monticello Avenue				d. STREET ADDRESS 109 Monticello Avenue			
3. NAME OF DECEASED (Type or print) BRIAN K. PALMER				4. DATE OF DEATH Month December Day 20 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1961	
9. AGE (In years last birthday) 5		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James A. Palmer III				14. MOTHER'S MAIDEN NAME Helen Mason			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT James A. Palmer III- Father- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard G. Shaub				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF December 22, 61			
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial				22d. LOCATION (City, town, or country) (State) Annapolis, Maryland			
23. FUNERAL DIRECTOR Hopping Funeral Home				24a. REC'D BY REGISTRAR DEC 26 '61			
24b. REGISTRAR'S SIGNATURE C. L. Kline							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13441

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 mo. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 929 N. Rosedale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis		Middle E.		Last Pinkney		4. DATE OF DEATH Month 12	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 3, 1889	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 72		IF UNDER 24 HRS. Days 72		Hours 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pinkney		14. MOTHER'S MAIDEN NAME Emma Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 214-01-7514	
17. INFORMANT Hospital Records		Address Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.B.S. Associated arteriosclerosis DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. 11/3 19 61 p. m. 12/8		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 11/3 19 61 to 12/8 19 61 , that (I) (we) last saw the deceased alive on 12/8 19 61 , and that death occurred at 1 PM , from the causes and on the date stated above.		22a. SIGNATURE Hildegard Heard Reissman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/8/61	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12.12.61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Md.		24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lan		25a. REC'D BY REGISTRAR DEC 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE DEC 13 '61		25d. REGISTRAR'S SIGNATURE Arthur S. Kraus		25e. DATE DEC 13 '61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13442

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 8 mos. 5 years 2 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 552 W. Lanvale St.			
3. NAME OF DECEASED (Type or print) First Arzzy Middle Last Pittman				4. DATE OF DEATH Month 12 Day 12 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 (June 3)	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Unknown Mannokin Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown Alex Pittman				14. MOTHER'S MAIDEN NAME Unknown Catherine Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4A3X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AHCD DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 4/10 19 56 to 12/12 1961, that (I) (we) last saw the deceased alive on 12/12 19 61 , and that death occurred 10:45 A.M., from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				22b. DATE 12/12/61		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-61		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph C. Russ				ADDRESS 2222 W. North Ave		25a. REC'D BY REGISTRAR DATE 12/14/61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Knack			

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TO HOSPITAL OR A N D I N G P H Y S I C I A N : The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED AT THE HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13462

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13443

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		d. STREET ADDRESS <u>155 West St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Mary Pratt</u>		4. DATE OF DEATH Month Day Year <u>12 19 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1907</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Parker</u>		14. MOTHER'S MAIDEN NAME <u>Ada Ann Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marie Smith Flowers</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 443X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Hypertensive cardiovascular disease Grade IV</u> (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12 1961</u> to <u>Dec. 18 1961</u> , that (I) (we) last saw the deceased alive on <u>December 18, 1961</u> , and that death occurred at <u>2:30a</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Johnson</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>		22d. ADDRESS <u>37 Calvert Street, Annapolis, Md.</u>	
22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u>		23d. LOCATION (City, town, or county) (State) <u>Davidsonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>DEC 20 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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CLINICAL OF TREAT

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Handwritten notes, possibly a medical record or clinical observation, including phrases like "Handwritten notes", "Clinical observation", and "Handwritten notes".

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13463 <i>Ann 730 - Ann cell house call - 11/9/60 - MRS</i> CERTIFICATE OF DEATH 14652									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 12 years 5 mos. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1613 N. Gilmore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sylvester		First		Middle		Last Rice		4. DATE OF DEATH Month 12 Day 30 Year 1961	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-30-5825		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) 491X DUE TO (c) (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic Cardiovascular Disease								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/27 , 19 49 , to 12/30 , 19 61 , that (I) (we) last saw the deceased alive on 12/30 , 19 61 , and that death occurred at 7:30 A.M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Hildegard Heard Reissman</i> 22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Crownsville State Hospital, Maryland		22b. DATE SIGNED 1/1/62	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Anatomy Board</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Don't bury</i>						25a. REC'D BY REGISTRAR DATE JAN 11 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Krane</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained at the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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13464
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13444

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 1 mo. 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle Last Ricks				4. DATE OF DEATH Month 12 Day 4 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> sep.		8. DATE OF BIRTH January 1, 1907	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 4-20-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary insufficiency (b) DUE TO (c) 		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				INTERVAL BETWEEN ONSET AND DEATH 	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While not at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 10/20 11:15 to 12/4 19 61 , that (I) (we) last saw the deceased alive on 12/4 19 61 and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Lionel McHenry Mapp				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 12/4/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant.,		23d. LOCATION (City, town, or county) (State) Norbeck, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE DEC 11 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED IN HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13465

CERTIFICATE OF DEATH

13445

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2 y, 4 mo, 10 d,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			d. STREET ADDRESS 1368 Whatcoat St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Priscilla Middle Rogers Last Rogers			4. DATE OF DEATH Month 12 Day 30 Year 19 61		
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1933 SEPT 19	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —					INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic diplegia, congen., Epilepsy, Mental deficiency					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 8/21		20g. (County) 19 59		20h. (State) 12/30	
21. I certify that (I) (this hospital) attended the deceased from 8/21 to 12/30 19 61 that (I) (we) last saw the deceased alive on 12/30 19 61 and that death occurred at 5:30 am from the causes and on the date stated above.					
22a. SIGNATURE Hildegard Heard Reissmann M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/30/61	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmann		22d. ADDRESS Crownsville State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-62		23c. NAME OF CEMETERY OR CREMATORY Carver Cem	
23d. LOCATION (City, town, or county) Laurel Md		(State) —			
24. FUNERAL DIRECTOR'S SIGNATURE Edw. S. Talson		24a. ADDRESS 1348 N. Calhoun St		25a. REC'D BY REGISTRAR DATE JAN 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

10-10-51

CONFIDENTIAL

10-10-51

(M)

IN THE

UNITED STATES DISTRICT COURT

James H. [illegible]

vs. [illegible]

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13466

CERTIFICATE OF DEATH

Reg. Dist. No. 13466

1. PLACE OF DEATH o. COUNTY <i>Sumner Knoll, Pasadena R7P MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Same</i> b. COUNTY <i>—</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>—</i>				c. LENGTH OF STAY IN 1b <i>20 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>Rae</i> Last <i>Scott</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 7, 1875</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Robert R. Rowe</i>				14. MOTHER'S MAIDEN NAME <i>Lilla Massey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Virginia B. Smida</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Colonial Thrombosis</i> DUE TO <i>4-20-61</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO <i>2 yrs</i> (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>61</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Nov 2</i> , 19 <i>61</i> , to <i>Dec 2</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Dec 2</i> , 19 <i>61</i> , and that death occurred at <i>5:20</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>105 Eastus Ave</i> DATE SIGNED <i>12/2/61</i>							
ACTUAL SIGNATURE <i>James S. Billingsley</i>				PHYSICIAN'S NAME (Type) <i>James S. Billingsley</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>5 Dec. 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. V. Singleton</i> ADDRESS <i>Glen Burnie Md.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 7, '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1328



1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Burial Place		17. Date of Burial		18. Signature of Burial Place	
19. Name of Undertaker		20. Date of Interment		21. Signature of Undertaker	
22. Name of Coroner		23. Date of Examination		24. Signature of Coroner	
25. Name of Medical Examiner		26. Date of Examination		27. Signature of Medical Examiner	
28. Name of Pathologist		29. Date of Examination		30. Signature of Pathologist	
31. Name of Anatomist		32. Date of Examination		33. Signature of Anatomist	
34. Name of Surgeon		35. Date of Examination		36. Signature of Surgeon	
37. Name of Physician		38. Date of Examination		39. Signature of Physician	
40. Name of Nurse		41. Date of Examination		42. Signature of Nurse	
43. Name of Hospital		44. Date of Admission		45. Signature of Hospital	
46. Name of Doctor		47. Date of Admission		48. Signature of Doctor	
49. Name of Patient		50. Date of Admission		51. Signature of Patient	
52. Name of Family		53. Date of Admission		54. Signature of Family	
55. Name of Community		56. Date of Admission		57. Signature of Community	
58. Name of State		59. Date of Admission		60. Signature of State	
61. Name of Nation		62. Date of Admission		63. Signature of Nation	
64. Name of World		65. Date of Admission		66. Signature of World	
67. Name of Universe		68. Date of Admission		69. Signature of Universe	
70. Name of Everything		71. Date of Admission		72. Signature of Everything	

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13468					13447									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 112 Ridgley Ave.									
3. NAME OF DECEASED (Type or print) Anna M. SHAWN					4. DATE OF DEATH December 2 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1882		9. AGE (in years last birthday) 79 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME LUDWIG MESSERSCHMIDTZ					14. MOTHER'S MAIDEN NAME CAROLINE PLITT									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT E. LOUISE SHAWN ANNAPOLIS MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated gastric ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus with coma										INTERVAL BETWEEN ONSET AND DEATH 11 1/2 days 6 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (the doctor) attended the deceased from Nov. 26, 1961 to Dec. 2, 1961 , that (I) 308 saw the deceased alive on Dec. 2, 1961 , and that death occurred at 8:10 PM from the causes and on the date stated above.										22b. DATE SIGNED 12/4/61				
22a. SIGNATURE Richard I. Hochman M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.					22d. ADDRESS 59 Franklin St., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)								
Cremation		12/4/1961		Fort Lincoln		Prince George Co. Md.								
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md					25a. REC'D BY REGISTRAR DEC 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13467

CERTIFICATE OF DEATH

13448

1. PLACE OF DEATH e. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
c. LENGTH OF STAY in lb <i>Years</i>		d. STREET ADDRESS <i>1 State Circle</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Anne Arundel General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gladys R Shifflet</i>		4. DATE OF DEATH <i>Dec. 16 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>FEB 3, 1928</i>
9. AGE (In years last birthday) <i>33 yrs.</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WAITRESS</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RESTAURANT</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Churchton Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>CLARENCE CLINTON CRANDALL</i>		14. MOTHER'S MAIDEN NAME <i>Thelma Matthews</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give year or dates of service)</i>		16. SOCIAL SECURITY NO. <i>217 240 018</i>	
17. INFORMANT <i>Mrs Gladys Hulse Shady Side Md</i>		Address <i>Cedarhurst</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Insulin shock</i> 260X DUE TO <i>Diabetic acidosis & coma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>Diabetes mellitus</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>6 days</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 11, 1961</i> , to <i>Dec. 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 15, 1961</i> , and that death occurred at <i>1:15</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Willard F. Smith</i> M.D.		22b. DATE SIGNED <i>12/16/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>		22d. ADDRESS <i>Shady Side, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/19/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>200ker</i>		23d. LOCATION (City, town or county) (State) <i>Ft. Belvoir Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Harduty</i> ADDRESS <i>Salisbury Md</i>		25a. REC'D BY REGISTRAR <i>DEC 21 '61</i> DATE	
25b. REGISTRAR'S SIGNATURE <i>Arthur J. Frank</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13469

CERTIFICATE OF DEATH

13449

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X CHURCHTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>JOSEPHINE</u> Middle <u>SIMMONS</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23, 1899</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BROADWATER, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. FRANK HOWES</u>		14. MOTHER'S MAIDEN NAME <u>VERDI V. TROTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>T. CLAYSON SIMMONS</u>		Address <u>CHURCHTON, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary thrombosis</u> DUE TO (b) <u>General weakened condition due to</u> DUE TO (c) <u>Carcinoma of breast & multiple metastases</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>61</u> , to <u>12/1/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/1/61</u> , 19 <u>61</u> , and that death occurred at <u>12/1/61</u> , 19 <u>61</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u> M.D.		22b. DATE SIGNED <u>12/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec 3 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Buater</u>		23d. LOCATION (City, town or county) (State) <u>Galeville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>		25a. REC'D BY REGISTRAR <u>Galeville Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>DEC 11 '61</u>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

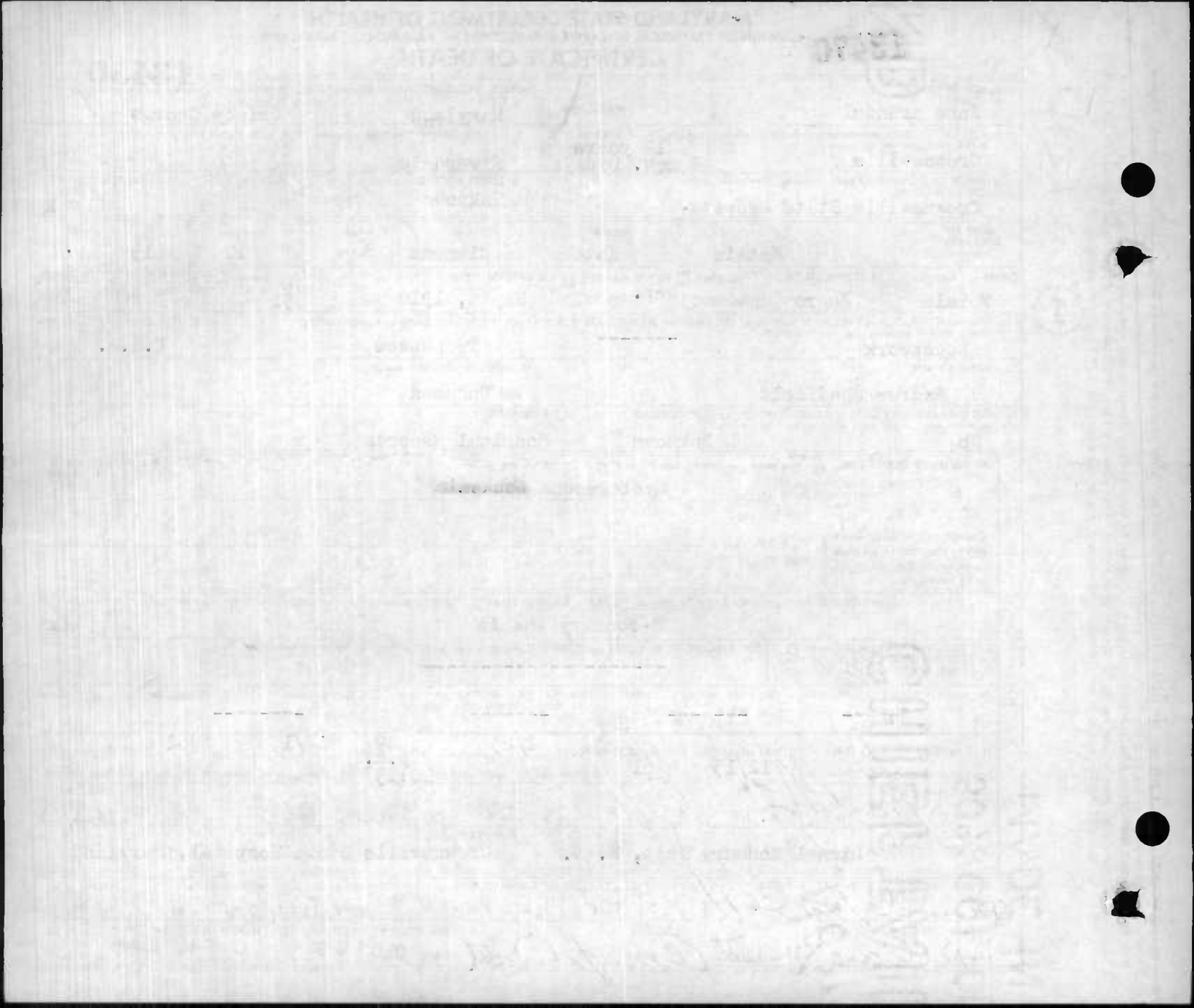
VR A15 (4)
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13470

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13450

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 12 years 9 mos. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Mattie Middle Kate Last Simmons				4. DATE OF DEATH Month 12 Day 13 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1910	
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months 12 Days 13 Hours 19 Min.		IF UNDER 24 HRS. Months 12 Days 13 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Sheffield				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 204.1 IMMEDIATE CAUSE (a) Myelogenous Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 10:15		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) 12/13 1961	
21. I certify that (I) (this hospital) attended the deceased from 2/23 1949 to 12/13 1961 , that (I) (we) last saw the deceased alive on 12/13 1961 , and that death occurred at 10:15 from the causes and on the date stated above.							
22a. SIGNATURE Lionel McHenry Mapp, M. D.				22b. DATE SIGNED 12/14/61		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-15-61		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese				25a. REC'D BY REGISTRAR DATE DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Pinner	



1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade		c. LENGTH OF STAY IN 1b Unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Odenton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kimbrough Army Hospital				d. STREET ADDRESS 1890A Annapolis Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Susan		Middle = L		Last Sisk	
4. DATE OF DEATH		Month December		Day 27		Year 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 July 1960		9. AGE (In years lost birthday) 1 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Sisk				14. MOTHER'S MAIDEN NAME Selva Meadows			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Father See item 13		Address See item 2D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 344.1 DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Mental and physical retardation (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Meningomyelocele						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1155		(County) 1155		(State) 1155	
21. I certify that (I) (this hospital) attended the deceased from November 19 60 to December 19 61 , that (I) (we) last saw the deceased alive on 27 December 61 , and that death occurred at 1155 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Sherman S. Robinson				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 28 Dec 1961	
22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, CAPT, MC				22d. ADDRESS Kimbrough Army Hospital Ft George G Meade, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1/2/62		23c. NAME OF CEMETERY OR CREMATORY Urbington National		23d. LOCATION (City, town, or county) (State) Urbington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE 6306 - Belvoir Rd, Baltimore 6, Md				25a. REC'D BY REGISTRAR DATE JAN 3 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13472

CERTIFICATE OF DEATH

13452

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 16 yrs. 7 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 723 George Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ada Frances Smith				4. DATE OF DEATH Month Day Year 12 28 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1894	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Burton				14. MOTHER'S MAIDEN NAME Marylish Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of the Endometrium of Uterus DUE TO (c) Paranoid Schizophrenia				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/29 1945 , to 12/28 1961 , that (I) (we) last saw the deceased alive on 12/28 1961 , and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Lionel McHenry Mapp</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-62		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Em A. A. Co		23d. LOCATION (City, town or county) (State) Ind	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Rayner Sanders</i>				25a. REC'D BY REGISTRAR DATE JAN 4 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

133-5

133-5



Exhibit 1-2-50 to 1-5-50
Exhibit 1-2-50 to 1-5-50

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13473

Item 1c Film 0305 1/12/62 ink

13453

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>30 days</u>		d. STREET ADDRESS <u>1618 W. Fayette St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alban</u> First <u>Smith</u> Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-92</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John A. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Emma E. Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Andrew Williams - 300 Sellers Pt. Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> DUE TO (b) <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from <u>4-30-1961</u> to <u>12-29-1961</u> , that (I) (we) last saw the deceased alive on <u>12-29-1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edison W. Pope</u>		22b. DATE SIGNED <u>12-30-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Crownsville State Hospital</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>A.A. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law - 802 Madison Ave.</u>		25a. REC'D BY REGISTRAR <u>JAN 4 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

12413

CERTIFICATE OF DEATH

12413

3-27-72

Hon. Andrew Williams - 3002 Walnut St. Phila.

A.A. Co., Md.

Serial 1-2-62 Mt. Calvary

Case No. 8-100-802-100-100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13474

Reg. Dist. No. 13454

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODLAND BEACH				d. STREET ADDRESS WOODLAND BEACH			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edgar First R. Middle Smith Last				4. DATE OF DEATH Dec. Month 6 Day 1961 Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1884		9. AGE (In years lost birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stat. engineer				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Egg Harbor, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Humphrey Smith				14. MOTHER'S MAIDEN NAME Purdy P. Perry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) ?				16. SOCIAL SECURITY NO. 150-07-8277		17. INFORMANT Address Mrs Elizabeth L. Buck- Daughter- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardio-vascular disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 22, 1961 to Dec 5th, 1961 , that I last saw the deceased alive on Dec 6, 1961 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Sylvia M. Lim M.D.				ADDRESS (Street, city or town, state) Rt 1, Box 277-M Edgewater, Md.				DATE SIGNED 12/6/61	
PHYSICIAN'S NAME (Type) Sylvia M. Lim									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Dec. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Asbury M.E. Cemetery			22d. LOCATION (City, town, or county) (State) Sommers Point, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.					24a. REC'D BY REGISTRAR DATE DEC 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345



1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 1930		6. BIRTH PLACE Memphis, Tennessee	
7. DECEASED DATE April 4, 1968		8. DECEASED TIME 2:01 PM		9. DECEASED PLACE Room 936, LBJ Library, Dallas, Texas	
10. CAUSE OF DEATH Shot		11. MANNER OF DEATH Suicide		12. PLACE OF DEATH Dallas, Texas	
13. SIGNATURE OF DECEASED (Signature)		14. SIGNATURE OF WITNESS (Signature)		15. SIGNATURE OF PHYSICIAN (Signature)	
16. SIGNATURE OF CORONER (Signature)		17. SIGNATURE OF JURY (Signature)		18. SIGNATURE OF STATE DEPARTMENT OF HEALTH (Signature)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13436

13416

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> (P.O. Box #21)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Old Annapolis Blvd.</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u> <u>E.</u> <u>HOHREIN</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13th Feb. 1914</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Herrmann</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <u>131 05 8353</u>		17. INFORMANT <u>Mr. Charles Mohrein</u>		Address <u>Same As # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>DEC 21, 1961</u> , to <u> </u> , 19 <u> </u> ; that (I) (we) last saw the deceased alive on <u>DEC 21, 1961</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Lankford Jr.</u>				22b. DATE SIGNED <u>12-23-61</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>	
22d. ADDRESS <u>PASADENA, MARYLAND</u>				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>27th Dec. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
25c. DATE <u>DEC 28 '61</u>				25d. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

13736

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13475

CERTIFICATE OF DEATH

13455

Item 9 Film G306 2/3/62 iwk

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CROWNSVILLE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE 3401-4			
c. LENGTH OF STAY in 1b 6 MO				d. STREET ADDRESS 712 CARROLLTON			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CROWNSVILLE STATE HOSP				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EVA COOKE SMITH				4. DATE OF DEATH Month 12 Day 26 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-28-18	
9. AGE (In years last birthday) 43 1/2 yrs.		10. IF UNDER 1 YEAR Months 4 Days 28 Hours 18 Min.		11. IF UNDER 24 HRS. Months 4 Days 28 Hours 18 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			
13. FATHER'S NAME SAMUEL COOKE				14. MOTHER'S MAIDEN NAME LAURA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. HOSPITAL RECORDS			
17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) TOXEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) GENERALIZED SKIN ULCERS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-16-1961 to 12-26-1961 that (I) (we) last saw the deceased alive on 12-26-1961 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John J. McGee				22b. DATE SIGNED DEC 29 1961		22c. PHYSICIAN'S NAME (Type) J. M'GEE	
22d. ADDRESS CROWNSVILLE HOSPITAL				22e. REC'D BY REGISTRAR DEC 29 1961			
22f. REGISTRAR'S SIGNATURE Arthur L. Evans				22g. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 30 Dec 1961		23c. NAME OF CEMETERY OR CREMATORY Balt. Nat'l Cem		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE WESLEY L. SULLIVAN				24. ADDRESS 1011 ARLINGTON			

1
The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1952

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13476
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13456

1. PLACE OF DEATH o. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 3 V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 6 y, 10 mo, 7 d.		d. STREET ADDRESS 430 E. Lanvale Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Junius Edward Smith		4. DATE OF DEATH Month Day Year 12 25 1961	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1892
9. AGE (In years (by birthday) yrs. 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Fannie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 402.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychomotor Epilepsy		INTERVAL BETWEEN ONSET AND DEATH 1 day over 5 ye.,	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/18 19 55 to 12/25 19 61 , that (I) (we) last saw the deceased alive on 12/25 19 61 , and that death occurred 3:50 am from the causes and on the date stated above.			
22a. SIGNATURE Hilda Reismann		22b. DATE SIGNED 12/26/61	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reismann		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City, town, or county) (State) A.A. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. E. Ellick		25a. REC'D BY REGISTRAR DEC 28 '61	
ADDRESS 1129 N. Caroline St.		25b. REGISTRAR'S SIGNATURE Clayton S. Kimes	

13478

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13477

Item 6 Film G304

13457

MEDICAL CERTIFICATION

13102

13102

(M)

Handwritten signature or initials

Handwritten text at the bottom of the page, possibly a date or reference number.

CERTIFICATE OF DEATH

Reg. Dist. No. 18454

13474

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODLAND BEACH				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edgar R. Smith				4. DATE OF DEATH Dec. 6 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1884	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stat. engineer				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Egg Harbor, N.J.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Humphrey Smith				14. MOTHER'S MAIDEN NAME Purdy P. Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ?				16. SOCIAL SECURITY NO. 150-07-8277		17. INFORMANT Mrs Elizabeth L. Buck- Daughter- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) disease				INTERVAL BETWEEN ONSET AND DEATH 7 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 20, 1961, to Dec 5th, 1961, that I last saw the deceased alive on Dec 6, 1961, and that death occurred at 7:25 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Sylvia M. Lim M.D.				Rt 1, Box 207-M 12/6/61			
PHYSICIAN'S NAME (Type) Sylvia M. Lim, Edgewater, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Asbury M.E. Cemetery		22d. LOCATION (City, town, or county) Sommers Point, Maryland, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '61	
24b. REGISTRAR'S SIGNATURE Anthony S. House							

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND:
13436
13416
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>Annopolis</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> (P.O. Box #21) d. STREET ADDRESS <u>Old Annapolis Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA E. MOHREIN</u>				4. DATE OF DEATH Month Day Year <u>DEC 23 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13th Feb. 1914</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Herrmann</u>				14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>131 05 8353</u>		17. INFORMANT <u>Mr. Charles Mohrein</u> Address <u>Same As # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>48 HOURS</u> <u>UNKNOWN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>DEC 21 1961</u> to <u>DEC 21 1961</u> , that (I) (we) last saw the deceased alive on <u>DEC 21 1961</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Lankford Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>PASADENA, MARYLAND</u>		22b. DATE SIGNED <u>12-23-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>27th Dec. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. K. Long</u> ADDRESS <u>Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1333



John H. ...

John H. ...

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13475 Item 9 Film G306 2/5/62 iwk													
13455													
1. PLACE OF DEATH a. COUNTY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE MARYLAND b. COUNTY MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3401-4							
c. LENGTH OF STAY IN 1b 6 MO						d. STREET ADDRESS 712 CARROLLTON							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CROWNSVILLE STATE HOSP						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FUA First Cooke Middle Smith Last						4. DATE OF DEATH 12 Month 26 Day 1961 Year							
5. SEX FEMALE		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-28-18 43442 yrs.		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME SAMUEL COOKE						14. MOTHER'S MAIDEN NAME LAURA SMITH							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. HOSPITAL RECORDS			17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 715X DUE TO (b) TOXEMIA Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) GENERALIZED SKIN ULCERS												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 10-16-1961 to 12-26-1961 that (I) (we) last saw the deceased alive on 12-26-1961 , and that death occurred at 5:30 M., from the causes and on the date stated above.													
22a. SIGNATURE John J. McGee M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) J. M'GEE						22d. ADDRESS CROWNSVILLE HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 30 Dec 1961		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem			23d. LOCATION (City, town or county) (State) Baltimore Md					
24. FUNERAL DIRECTOR'S SIGNATURE WESLEY L. SULLIVAN ADDRESS 1011 ARLINGTON AVE						25a. REC'D BY REGISTRAR DEC 29 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				

1935

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be refiled by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

13476
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13456

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 3 V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN lb 6 y, 10 mo, 7 d.		d. STREET ADDRESS 430 E. Lanvale Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Junius Edward Smith		4. DATE OF DEATH Month 12 Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1892
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 12 Days 25 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Fannie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions: if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Disease (b) over 5 ye., (c) Psychomotor Epilepsy		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychomotor Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/18 19 55 , to 12/25 19 61 , that (I) (we) last saw the deceased alive on 12/25 19 61 , and that death occurred 3:50 AM from the causes and on the date stated above.			
22a. SIGNATURE Hilda Reismann		22b. DATE SIGNED 12/26/61	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reismann		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City, town, or county) (State) A.A. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Myrtle E. Ellickson		25a. REC'D BY REGISTRAR DEC 28 '61	
ADDRESS 1129 N. Caroline St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kimes	

STATE OF TEXAS

18478

IN SENATE

January 1, 1847

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

TO THE

LEGISLATURE

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 305
1-12-62 ams

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13457

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years, last birthday)		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage from the Lungs</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Pulmonary tuberculosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? Part I <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard G. Shaub</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED 12/7/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Arthur S. Kroll</u>		24a. REC'D BY REGISTRAR DEC 11 '61	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kroll</u>		DATE	

(M)

Cambridge, Mass.

January 12, 1901

My dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

Enclosure

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13478

CERTIFICATE OF DEATH

Reg. Dist. No. 13458

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 143 Spa Drive		d. STREET ADDRESS 143 Spa Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIOLA Middle W Last STEHLE		4. DATE OF DEATH Month DECEMBER Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16, 1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Williams		14. MOTHER'S MAIDEN NAME Jessie HETZEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-16-1383	
17. INFORMANT Mrs. Jeannet S. Irons- Daughter- Arnold, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-17 , 19 61 , to 12-17 , 19 61 , that I last saw the deceased alive on 12-17 , 19 61 , and that death occurred at 930 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 73 Franklin Street, Annapolis, Maryland DATE SIGNED 12/18/61			
ACTUAL SIGNATURE Edward S. Beck M.D.			
PHYSICIAN'S NAME (Type) Edward S. Beck		73 Franklin Street, Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20, 1961	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DEC 22 '61		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13479				CERTIFICATE OF DEATH				13459			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 103 Northwest St.					
3. NAME OF DECEASED (Type or print) Elizabeth (ELIZAH) STEVENS						4. DATE OF DEATH December 26 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-1-1891		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Settled				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Stevens						14. MOTHER'S MAIDEN NAME Mary Snowden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) NO						16. SOCIAL SECURITY NO. 331X					
17. INFORMANT Katherine Murray - Annapolis, Md.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm + Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Basal Pneumonia, chronic. DUE TO (c) Coronary vascular accident						INTERVAL BETWEEN ONSET AND DEATH about 2 wks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec. 11, 1961 to Dec. 25, 1961		20g. (County) St. Margaret's, Md.		20h. (State) St. Margaret's, Md.	
21. I certify that (I) (Signature) attended the deceased from Dec. 11, 1961 to Dec. 25, 1961 , that (I) (Signature) saw the deceased alive on Dec. 25, 1961 , and that death occurred at 3:45 AM , from the causes and on the date stated above.											
22a. SIGNATURE A. T. Allen						22b. DATE SIGNED DEC 26 '61					
22c. PHYSICIAN'S NAME (Type) A T ALLEN						22d. ADDRESS 62 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 12-29-61		23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City, town or county) St. Margaret's, Md.		23e. (State) St. Margaret's, Md.		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, D-Annapolis, Md.						25a. REC'D BY REGISTRAR DEC 26 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		25c. DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13460

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Ann c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester d. STREET ADDRESS Box 222 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle E Last Stevenson		4. DATE OF DEATH Month 12 Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 17 Days 8 Hours 2 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Worker & Butler		11b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stevenson		14. MOTHER'S MAIDEN NAME Edith Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old Cerebro-vascular Accident DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 years Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- 19	20d. INJURY OCCURRED While ----- of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 11/28 1961 , to 12/4 1961 , that (I) (we) last saw the deceased alive on 12/4 1961 , and that death occurred at 8:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Lionel McHenry Mapp</i>		22b. DATE 12/4/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/61	
23c. NAME OF CEMETERY OR CREMATORY Chester Corn		23d. LOCATION (City, town, or county) (State) Chester Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Radford</i>		25a. REC'D BY REGISTRAR DATE DEC 7 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

10010

UNITED STATES DEPARTMENT OF THE INTERIOR

10010

TO THE SECRETARY OF THE INTERIOR, WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF LAND MANAGEMENT

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13481

13461

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. D.C. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7 mo. 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Washington 6501 Ritchie Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Lincoln Last Stewart				4. DATE OF DEATH Month 12 Day 13 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 25, 1874	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 12 Days 13 Hours 19 Min.		IF UNDER 24 HRS. Months 12 Days 13 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 177X DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 5/4 19 54 to 12/13 19 61 , that (I) (we) last saw the deceased alive on 12/13 19 61 , and that death occurred at 7:10 P. M., from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				22b. DATE SIGNED 12/14/61			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-2061		23b. DATE THEREOF 12-2061		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City, town, or county) (State) Huntersville M.D.	
24. FUNERAL DIRECTOR'S SIGNATURE Malvern Schey Inc				25a. REC'D BY REGISTRAR 424 R St NW			
25b. REGISTRAR'S SIGNATURE REC 26 '61				25c. REGISTRAR'S SIGNATURE -----			

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH

1948

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "DEPARTMENT OF HEALTH" and "1948" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If the deceased was retained by a hospital or attending physician, the low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13482

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13462

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 A - Street S.W. (Home)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>110 A- Street S.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>M.</u> Last <u>Stinchcomb</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 March 1874</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor-Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alfred A. Stinchcomb</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Stinchcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Victor Stinchcomb</u> Address <u>110 A- Street SW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cardio-Vascular Disease</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1874</u> to <u>Dec 18</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James S. Billingslea</u>				22b. DATE SIGNED <u>Dec. 20, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>James S. Billingslea</u>	
22d. ADDRESS <u>108 Central Ave. N.W. Glen Burnie</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21 Dec. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Methodist</u>		23d. LOCATION (City, town, or county) (State) <u>Arnold Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Orlino S. Thomas</u>	

0

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99



1510

13403

1. Name of the establishment: _____

2. Address: _____

3. City: _____

4. State: _____

5. Zip: _____

6. Name of the person: _____

7. Title: _____

8. Date: _____

9. Signature: _____

10. Name of the person: _____

11. Title: _____

12. Date: _____

13. Signature: _____

14. Name of the person: _____

15. Title: _____

16. Date: _____

17. Signature: _____

18. Name of the person: _____

19. Title: _____

20. Date: _____

21. Signature: _____

22. Name of the person: _____

13483

CERTIFICATE OF DEATH

13463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 Hillcrest Ave.				d. STREET ADDRESS 406 Hillcrest Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY CROMWELL THOMPSON		First Middle Last		4. DATE OF DEATH DECEMBER 20 1961		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1882		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington L. Slaughter				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Henry M. Thompson- Husband - same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Cardio-vascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 20, 1957 , to Dec. 20, 1961 , that I last saw the deceased alive on 12/19 , 19 61 , and that death occurred at 6:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Samuel Rubin		M.D. 201 Patapsco Ave. Brooklyn, Maryland					
PHYSICIAN'S NAME (Type) Sam Rubin M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE DEC 26 '61	
				24b. REGISTRAR'S SIGNATURE Caroline E. Thomas			

VS A15 (4)
15M 10/57

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, and 3 should be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13484

CERTIFICATE OF DEATH

13464

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fernside</u>		c. LENGTH OF STAY IN TB <u>20 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>AA</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>238 Annapolis Rd.</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Jane Linley</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27 1874</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Beals Island Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>(unknown)</u>			
14. MOTHER'S MAIDEN NAME <u>Cornelia White</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>NOTE</u>				17. INFORMANT <u>James Webster Linley</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerosis</u> (c), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21/61</u> to <u>12/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/21/61</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr., M.D.</u>				22d. ADDRESS <u>Linthicum Hgts Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-23-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</u>				25a. REC'D BY REGISTRAR <u>DEC 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

1943

CERTIFICATE OF DEATH

1943

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

Covered by Bill, Jr., N.Y.

Wm. Cook, Inc., 1115 N. Park Street, N.Y.C. 5
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JAN 11 1943

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>R. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Smithfield St.</u>		d. STREET ADDRESS <u>912 Smithfield St.</u>	
3. NAME OF DECEASED (Type or print) <u>William D. Tongue</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Tongue</u>		14. MOTHER'S MAIDEN NAME <u>Sally Henson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mary Downs Harwood Md</u>	
17. INFORMANT <u>Mary Downs Harwood Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Right</u> 1960 DUE TO <u>Suppurative Myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) last saw the deceased alive on 19____, and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Richardson</u>		22b. DATE SIGNED <u>12/11/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>RICHARDSON M.D.</u>		22d. ADDRESS <u>110-CHERRY ST ANN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-14-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bronner Hill</u>		23d. LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
25a. REC'D BY REGISTRAR <u>DEC 13 '61</u>		25b. REGISTRAR'S SIGNATURE	

DATE

VEHICLE NO.

1983



[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13486

CERTIFICATE OF DEATH

Reg. Dist. No. 13466

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis - 50 Fleet Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMOS Middle TURNER Last		4. DATE OF DEATH Month Dec. Day 3 Year 19 61	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20- 1900
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repairing	
11. BIRTHPLACE (State or foreign country) Montecella- Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Turner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-0229	
17. INFORMANT Pauline Turner-106 South Street-Anna. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease and Diabetes Mellitus DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1960 , to Dec. 3, 1961 , that I last saw the deceased alive on Oct. 23, 1961 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Theodore H. Johnson, M. D. DATE SIGNED ACTUAL SIGNATURE Theodore H. Johnson M.D. PHYSICIAN'S NAME (Type) T.H. Johnson 37 Calvert St. Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8-61	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. HICKS III		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR DATE DEC 13 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Krawe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12282



Name of Deceased		Date of Birth	
John J. Smith		Jan 15, 1890	
Sex		Age	
Male		37	
Place of Birth		Date of Death	
New York City		Jan 20, 1927	
Cause of Death		Place of Death	
Heart Disease		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Manner of Death		Occupation	
Natural		Clerk	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Issuance	
Jan 22, 1927		New York City	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13487
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13467
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 98 College Creek Terrace			d. STREET ADDRESS 98 College Creek Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CATHERINE LENORA JOHNSON TURNER			4. DATE OF DEATH Dec 17 19 61		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22-1916		9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland	
13. FATHER'S NAME John A. Johnson			14. MOTHER'S MAIDEN NAME Elizabeth S. Johnson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-16-1910		17. INFORMANT Elizabeth S. Randall-98 College Creek Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the uterus 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dec 15, 1961	
20f. (City or town) Annapolis		20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Dec 17, 1961 to Dec 17, 1961 , that (I) was last saw the deceased alive on Dec 17, 1961 , and that death occurred at 11:45 P.M. the causes and on the date stated above.					
22a. SIGNATURE R. J. Richardson			22b. DATE SIGNED Dec 12, 1961		
22c. PHYSICIAN'S NAME (Type) R. J. Richardson			22d. ADDRESS 110 Clay St. Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-61		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	
23d. LOCATION (City, town or county) Annapolis, Md.		23e. REC'D BY REGISTRAR DEC 22 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks 111 Annapolis, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13488					13468				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>19 yrs 3 mo 19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROUNSVILLE STATE</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN 2103-2</u> d. STREET ADDRESS <u>651 Penna Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Eugene</u> Last <u>Tyler</u>					4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1961</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1897</u>		9. AGE (In years last birthday) <u>64</u> yrs. <u>0</u> mo. <u>14</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>County - WASHINGTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>SAMUEL EDWARD TYLER</u> <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>MARY PIERCE</u> <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>651 Penna Hagerstown</u> <u>Mrs John Hall (sister)</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO <u>4-22-61</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO <u>24 hrs.</u> (c) <u>Idiot MENTAL DEFECTIVE SEVERE</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-4-50</u> , 19 <u>61</u> to <u>12-23-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-23-61</u> , 19 <u>61</u> , and that death occurred at <u>9-4-50</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>George McK. Phillips</u>					22b. DATE SIGNED <u>12-23-61</u>		22c. PHYSICIAN'S NAME (Type) <u>George McK. Phillips</u>		
22d. ADDRESS <u>CROWNsville, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>Dec. 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u>					24b. ADDRESS <u>Williamsport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

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FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14653

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First <i>Unknown</i>		Middle <i>Unknown</i>		Last <i>Unknown</i>		4. DATE OF DEATH <i>Feb 24 - 1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>unknown</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Unknown - (Newborn)</i>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <i>2</i> Days <i>24</i> IF UNDER 24 HRS. Hours <i>7</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia - Face wrapped in plastic bag</i> DUE TO (b) <i>in plastic bag</i> DUE TO (c) <i>in plastic bag</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found in Woods - Face wrapped in plastic bag</i>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>Unknown</i> p.m. <i>Unknown</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Field</i>		20f. (City or town) <i>A.A.</i> (County) <i>md.</i> (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)									
ACTUAL SIGNATURE <i>R.F. Fisher</i>		EXAMINER'S NAME (Type) <i>R.S. Fisher</i>		DATE SIGNED <i>12/25/61</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1-9-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>W. Ind. Med. School</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
23. FUNERAL DIRECTOR ADDRESS					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Hanna</i>		
					DATE <i>JAN 11 '62</i>				

VS. A15ME
5M 9/60

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is not necessary. Give Pages 1, 2, and 3 to the funeral director. (Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files.) TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(M)

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FOR STATE
HEALTH DEPT.

13490
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13469

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN 1b 25 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Annapolis Blvd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John White		4. DATE OF DEATH Month 22 Day 22 Year 1961	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/79 9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired labor.		10b. KIND OF BUSINESS OR INDUSTRY A.A. County, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur White		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Marjorie Howard (daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charred above recognition 9/16.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Was trapped in his house which burned down.			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 A.M. p.m. 12/22/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Severna Park A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/22/61 DATE SIGNED Address (Street, city, town, or county) Glen Burnie, Md.			
ACTUAL SIGNATURE Gustave H. Faubert EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-24-61 22c. NAME OF CEMETERY OR CREMATORY Carpenter Hill 22d. LOCATION (City, town, or country) Severna Pk, Anne Arundel Co Md	
23. FUNERAL DIRECTOR Charles E. Hicks, 11 Annapolis, Md		24a. REC'D BY REGISTRAR DEC 27 '61 24b. REGISTRAR'S SIGNATURE Charles E. Hicks	

VS. A15M
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or delay is necessary, within 72 hours after death. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF JUSTICE

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13491

13470

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Greenwood St.		d. STREET ADDRESS 15 Greenwood St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle A Last WHITTLE		4. DATE OF DEATH Month Dec. Day 27 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1887
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Ret. Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Odenton, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Whittle		14. MOTHER'S MAIDEN NAME Annie M. Watts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-32-9162	
17. INFORMANT Mrs. Beverly Wood- Daughter- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Emboli 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 10 min. 20 yr. 20 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec 24, 1961 to Dec 27, 1961 that (I) (we) last saw the deceased alive on Dec 27, 1961 and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert L. Damm		22b. DATE SIGNED 12/24/61	
22c. PHYSICIAN'S NAME (Type or print) ROBERT L. DAMM		22d. ADDRESS 106 CHENLEA DRIVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY BETHEL NICHOLS		23d. LOCATION (City, town, or county) (State) ODENTON, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR DATE JAN 3 '62	
ADDRESS Glen Burnie, Md		25b. REGISTRAR'S SIGNATURE Robert L. Damm	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13492 CERTIFICATE OF DEATH 13471

1. PLACE OF DEATH a. COUNTY <i>AA</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Jacobs Mills</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Jacobs Mills</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Four Smallwood Rd</i>		d. STREET ADDRESS <i>Four Smallwood Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Edward Williams</i>		4. DATE OF DEATH Month Day Year <i>12 / 27 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-21-90</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Am Label</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>Luke</i>		14. MOTHER'S MAIDEN NAME <i>Mary Fogler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If assigner or dates of service)</i>	
17. INFORMANT <i>Family - Name</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Carcinoma of stomach</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>7 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <i>July 1961</i> to <i>Dec. 27, 1961</i> , that (I) last saw the deceased alive on <i>Dec. 20</i> 1961, and that death occurred at <i>2:45</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>C. Earl Hill</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>C. EARL HILL</i>		22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/30/61</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		23d. LOCATION (city, town or county) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. E. G. Fogler</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 29 '61</i>	
ADDRESS <i>130 E. Fogler Ave.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

13432

(M)

13431

John Edward Williams 12/27/21

Winters, the first
little
house

Metastasis
of tumor

Dec 20 21
21/21

C. EARL HILL
1700
1700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 must be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13493

13472

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dead on arrival to Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Martin ZEHNER		4. DATE OF DEATH 12 15 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	11. BIRTHPLACE (County & State, or foreign country) Germany
13. FATHER'S NAME Andrew Zehner		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT Mrs. Mariea Zehner- Wife- Same as #2	
16. SOCIAL SECURITY NO. 218-36-1498		17. INFORMANT Mrs. Mariea Zehner- Wife- Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 44 DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiac Hypertrophy (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Not Known 5 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1961 to Dec 1961 , that (I) (we) last saw the deceased alive on Dec 12 1961 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Francis I. Codd		22b. DATE SIGNED 12-16-61	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd, M.D.		22d. ADDRESS Governor Ritchie Highway Severna Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 19, 1961	
23c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows		23d. LOCATION (City, town or county) (State) Owensville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR DEC 19 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

13103



John V. ...

Marjorie

John V. ...

David ...

David ...

David ...

John ...

Dec. 12, 1932

Dec. 12, 1932

Gary

Tobacco

Patricia ...

John ...

John ...

John ...

John ...

John ...

John ...